Supreme Court, U. S.
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IN THE

Supreme Court of the United States

October Term, 1975

No. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. AND J. R., Minors, individually and as representatives of a class of persons similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

JURISDICTIONAL STATEMENT

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May, 1976

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SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1975

NO.

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. AND J. R., Minors, individually and as representatives of a class of persons similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE MIDDLE
DISTRICT OF GEORGIA

JURISDICTIONAL STATEMENT

This is an appeal from the Order and Judgment of the United States District Court for the Middle District of Georgia, entered February 26, 1976, and March 11, 1976, respectively, which enjoined the Appellants

from enforcing that portion of Ga. Code § 88-503.1(a), which authorizes the parents and guardians of persons younger than 18 years of age to make application to a State mental health facility for the voluntary admission of their children, with the concurrence of the attending physician, for observation, diagnosis and for treatment of mental illness. The district court, in enjoining the operation of Ga. Code § 88-503.1(a), held that minors are constitutionally entitled to contest their parents' or guardians' decision and, further, are constitutionally entitled to receive from the State treatment for their mental illness in the "optimally appropriate" treatment setting commensurate with the minor's condition, irrespective of the availability of such settings. Absent such a setting, the district court ordered, the State was enjoined from providing any treatment at all.

This statement is presented to show that the Supreme Court of the United States has jurisdiction in this matter and that substantial questions are presented by the decision of the district court.

OPINIONS BELOW

The Order of the district court from which this appeal is taken is not yet reported. A copy is attached hereto as Appendix A.

The Judgment of the district court from which this appeal is taken is not yet reported. A copy is attached hereto as Appendix B.

JURISDICTION

The Appellees, as representatives of a class of persons under 18 years of age admitted to State mental health facilities upon application by their parents or guardians, and concurrence by the attending physician, filed an action on October 24, 1975, seeking an injunction against the enforcement of Ga. Code § 88-503.1(a), which permits the superintendent of any State mental health facility to receive for observation and diagnosis,

> "any individual under 18 years of age for whom such application is made by his parent or guardian . . . . If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment . . . ."

Appellants, as executive officers of the State agency responsible for the State's provision of mental health services, were named as defendants.

The jurisdiction of the district court was predicated upon 28 U.S.C. § 1343 on Appellees' claim under 42 U.S.C. § 1983, that the challenged statute denied persons under 18 years of age rights guaranteed by the due process clause of the Fourteenth Amendment to the Constitution of the United States.

The Appellees sought the impanelling of a three-judge district court in order to determine the issue and, pursuant to 28 U.S.C. § 2281, a three-judge district court was convened to hear the matter.

On February 26, 1976, based on a holding that the Appellees' rights to procedural due process had been violated, the three-judge district court enjoined the Appellants from enforcing the provisions of Ga. Code § 88-503.1(a) and also ordered the Appellants to place all persons under 18 years of age then or thereafter found in State mental health facilities in that treatment setting which would provide the "optimally appropriate" treatment commensurate with each person's condition or to remove them from State custody.

On March 11, 1976, the three-judge district court entered a judgment based on the Order of February 26, 1976, in which the terms and provisions of the district court's order of February 26, 1976, were made the final judgment of the court.

The Appellants filed their notice of appeal from that Order and Judgment in the United States District Court for the Middle District of Georgia on March 24, 1976. A copy of that notice is attached as Appendix C.

The jurisdiction of this Court to review by direct appeal the Order and Judgment of the district court granting the relief sought by the Appellees is conferred by 28 U.S.C. § 1253. See also Golden v. Zwickler, 394 U.S. 103 (1969); Flemming v. Rhodes, 331 U.S. 100 (1947).

STATUTES INVOLVED

The challenged statute, Ga. Code § 88-503.1(a) (Ga. Laws 1969, pp. 505, 517), provides:

> "The superintendent of any facility may receive for observation and diagnosis any individual 18 years of age, or older, making application therefor, any individual under 18 years of age for whom such application is made by his parent or guardian and any person legally adjudged to be incompetent for whom such application is made by his guardian. If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment in such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law."

QUESTIONS PRESENTED

1. Whether the Due Process Clause of the Fourteenth Amendment requires parents, or persons standing in their stead, to secure judicial approval, in an adversarial proceeding against their child, prior to securing for that child medically-indicated institutional mental health services afforded by the State.

2. Whether the State's interest in the maintenance of the family structure and the family as an integral unit of society, outweighs a minor child's interest in receiving any constitutionally

mandated procedural due process prior to being admitted to a State mental health facility.

3. Whether, assuming that more than one treatment setting would benefit a mentally ill person under 18 years of age, the Fourteenth Amendment to the Constitution of the United States mandates that the State must, if it is to provide services at all, provide needed mental health services in the most optimally appropriate treatment setting commensurate with the minor's condition.

STATEMENT OF THE CASE

In 1969 Georgia adopted a comprehensive and substantially modernized mental health code, codified as Ga. Code Ch. 88-5 (Ga. Laws 1969, p. 505). One major thrust of this code was to insure that any person who was in need of mental health services and who wished to voluntarily seek State provided treatment could do so. Recognizing that minors are incapable, because of their minority, of making such an informed consent as would enable them to receive mental health treatment, see e.g., Ga. Code § 88-2904, the General Assembly of Georgia provided that the parents or guardian of a person under 18 years of age could act for their child in seeking voluntary treatment for the child's mental illness. Ga. Code § 88-503.1 (a).

On October 24, 1975, this action was filed by the Appellees, two children admitted to a State mental health treatment facility pursuant to Ga. Code § 88-503.1(a), seeking to enjoin the enforcement of that provision of Ga. Code § 88-503.1(a), which

recognizes that parents or guardians may make application for admission to a mental health facility for their children under 18 years of age, and allows State facilities to provide such requested mental health services upon the concurrence of the attending physician that such services are suitable. The statute was challenged on the ground that it was constitutionally deficient in several respects.

The Appellees first alleged that they were not voluntary patients, but in fact were involuntarily committed to and incarcerated in a State mental health facility without having been afforded a meaningful and complete opportunity to be heard and, consequently, they had been deprived of their liberty without procedural due process of law.

Second, the Appellees alleged that through the operation of the challenged statute, they were placed directly in a mental health facility without any initial consideration of placement in a less restrictive environment, and therefore the Appellees had again been denied their liberty without due process of law in violation of the Fourteenth Amendment to the Constitution of the United States.

Shortly after the suit was filed, on November 19, 1975, a three-judge district court was convened and a hearing was held to consider the claims made by the Appellees. After receiving oral argument on the legal issues presented by the complaint, the court directed that the matter be submitted by stipulation and upon testimony taken by deposition.

The Appellants' position at the hearing, and at all times pertinent hereto, was that the decision of a parent to seek hospitalization for a child is a decision properly made by the parent or guardian who is charged under Georgia law, see e.g., Ga. Code § 74-105, with the power and duty to provide for the "maintenance, protection and education of their children." The Appellants argued that the children's protection, if any were required, lay in the fact that parents or guardians could only make application for admission to the State mental health facility, and that the child could not be admitted unless the superintendent of the facility, a physician, found that the child showed signs of mental illness and was suitable for treatment in that facility.

The evidence adduced below primarily related to the operation of Ga. Code § 88-503.1(a) in practice and the value of alternatives to that statute suggested by Appellees. Several facts which bear on the constitutionality of Ga. Code § 88-503.1 (a) can be gleaned from that evidence.

Intially, there was not a scintilla of evidence which indicated that a single child had ever been admitted to a State mental health facility who did not have symptoms of mental illness and who was not amenable to treatment at the State mental health facility to which the child was admitted.

The evidence also established that each mental health facility had policies and practices which resulted, prior to the admission of the mentally ill child to that facility, in the consideration of alternative placements for the child.

The evidence further showed that each facility conducted careful screening before admission to insure that the child in fact was mentally ill and suitable for treatment in that particular facility.

With respect to the issue of the appropriateness of the treatment setting, the evidence indicated that fifty (50%) percent of all children admitted under the challenged code section were released within sixty (60) days of their admission and that eighty (80%) percent were discharged within six months. Other evidence demonstrated that there was a dispute between experts and conflict in the empirical data available as to whether in fact there was any benefit or harm to a minor child who was placed in one particular treatment setting as opposed to another.

More importantly with respect to this issue, there was no evidence introduced which demonstrated any restrictions, or lack of restrictions, which would be imposed upon any child because of his placement in one type of treatment facility as opposed to another, a significant consideration in light of the district court's order. That is, while there were descriptions of what a group home consisted of as opposed to an adolescent unit in a regional hospital, there was no evidence to show in fact that any minor child would have any less restriction on his freedom to do as he pleased as a result of being placed in any particular treatment setting.

Finally, the evidence below demonstrated that the Department of Human Resources, the agency charged with the administration of State-provided mental health services, did not

have sufficient funds, and would not have them, to provide the range of "optimally appropriate" treatment settings for those children presently in its custody, much less for all those who might in the future be committed to its custody.

However, on February 26, 1976, the three-judge district court entered an order in which it held that the challenged statute and the practices of the Appellants were unconstitutional. The district court did three things. First, it permanently enjoined and restrained the Appellants from further detaining or confining any child under 18 years of age in any mental health facility in the State of Georgia pursuant to a voluntary admission by a parent or guardian under the challenged provisions of Ga. Code § 88-503.1(a). Second, the court ordered, with respect to those children who were then in State mental health facilities, that the Appellants either (1) commence proceedings within 60 days under some law not found to be unconstitutional to obtain proper legal authority to detain the Appellees or (2) to make necessary arrangements to completely remove the children from the custody of the Appellants or any other official or agency of the State of Georgia. Third, the Court ordered that, with respect to those children for whom a hospital was not the "optimally appropriate treatment setting", Appellants provide the necessary physical resources and personnel for whatever non-hospital facilities were deemed to be most appropriate for those children.

On March 11, 1976, the three-judge district court entered a judgment based on the Opinion and Order entered February 26, 1976, incorporating its conclusions and directions as set forth above.*

THE QUESTIONS ARE SUBSTANTIAL

1. Where a parent or guardian, acting on the advice and concurrence of a physician, determines that a minor child is mentally ill and in need of treatment and seeks that treatment in a State-owned or operated mental health facility, the child is not entitled to any constitutionally mandated procedural due process through which his parents' or guardian's decision may be challenged and the judgment of a State court substituted for that of his parents.

The impact of the decision of the district court, viewed narrowly, can be simply stated. If the decision of the district court is allowed to stand, no parent or guardian in the State of Georgia will be allowed to seek in-patient treatment for a mentally ill child in a State-owned or operated facility except by filing a petition in the appropriate court seeking a judicial determination, after an adversarial hearing, on the question of whether the child is in fact mentally ill and in need of treatment. Simply because

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* Appellants sought a stay of the district court's Order and Judgment pending appeal. That application was denied. Appellants then applied to this Court for a stay pending appeal. This Court granted the application.

State facilities are to be involved, the district court's decision requires the substitution of a judicial decision for a decision traditionally and rightfully allocated to parents and guardians prior to the family's obtaining of the needed and desired mental health services for a mentally ill child.

The district court's conclusion was premised on a fear of abuse of parental power and physician responsibilities, articulated by the district court as simply that the statute

> "affords to parents, guardians, the Department of Human Resources as Custodian, and superintendents the 'unchecked and unbalaced (sic) power over [the] essential liberties . . .' of these children that is universally mistrusted by our 'whole scheme of American government.'"

Such a conclusion is completely without legal precedent and its premise is totally without factual support in this record. Such a conclusion and the premise on which it is founded undermines a doctrine established by a long history of decisions by this Court.

This Court has not yet ruled as to whether a child has any constitutionally protected rights when he is unhappy with his parent or guardian who is attempting to exercise authority traditionally recognized as being within the parents' province, simply because the State aids, enforces, or defers to that decision.

This Court has recognized the importance of this specific issue, the question of the constitutional rights of a minor when the child and parent take opposing positions and the State seeks to assist the parent in implementing the parent's decision. In Wisconsin v. Yoder, 406 U.S. 205 (1972), this Court stated that the recognition of such a claim of competing interests between a parent and a child would call into question traditional judicial concepts of parental control over the upbringing of their minor children recognized in past court decisions. Specifically, the traditional judicial concept is embodied in the notion that the custody, care and nurture of a child resides first in the parents whose primary function and freedom the State can neither supplant nor hinder. See Pierce v. Society of the Sisters, 268 U.S. 510 (1925).

Georgia, in this instance as in most other cases, has deferred to parental judgment. In doing so, Georgia has done no more than recognize society's long-standing judgment. Indeed, the powers of the Georgia juvenile court system to order provision of mental health services for children, Ga. Code § 24A-2601, is premised on parental failure to exercise responsibility. See Comment, Ga. Code Ann. 1975 Cumm. Supp. to Book 9A, at p. 132.

If the district court's conclusion and its premise are correct, the impact on the delivery of mental health services to children in need of those services is drastic enough. But it portends a far

greater impact on the State's provision of other services to children, including physical health services, at the request of the parents. It portends a never ending constitutional review of instances of State deference to parental authority and the substitution of the judiciary of the State as the ultimate parent.

Hence, the decision of the district court, which created rights in children in matters traditionally decided by their parents and which held that in fact the children's rights were superior to that of the parent, has called into question those traditional judicial concepts acknowledged in Wisconsin v. Yoder, supra, clearly presents a substantial question which should be reviewed by this Court and unequivocably rejected.*

2. Even if a person under 18 years of age has a liberty interest which might be protected by the Fourteenth Amendment to the Constitution of the United States, the infringement on this right by the State in its support of the decision of the parent or guardian may be allowed if the State has decided that the preservation of the family structure is an integral part of the preservation of society and

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* On March 22, 1976, this Court noted probable jurisdiction in the matter of Kremens v. Bartley, 75-1064, 44 U.S.L.W. 3525, a case which involved two Pennsylvania statutes which also allowed a parent or guardian to make application to admit or commit a minor child to a State mental health facility.

that the failure to allow parents to seek proper mental health treatment for their children will undermine this family structure.

This Court has recognized in Cafeteria and Workers' Union, etc. v. McElroy, 367 U.S. 886 (1961), that the due process clause of the Fourteenth Amendment to the Constitution of the United States does not require a hearing "in every conceivable case of government impairment of private interest". This Court has held that what procedures due process may require in any given set of circumstances must begin with a determination of the precise nature of the government function involved as well as the private interests that have been affected by the government action.

In the matter at bar, the private interests are (1) the asserted "right" of the child not to receive in-patient treatment for a mental illness and (2) the right and duty of the parent to provide proper medical care for his child. The interest of the State is in supporting the family structure by reenforcing the parental decision that such in-patient treatment will be given to the child. The decision of the district court is that the right and duty of the parents, even when considered with the State's interest in the preservation of the family structure, does not outweigh the "right" of the minor child to refuse to receive in-patient mental health treatment without first being afforded an adversarial hearing in a judicial forum to test the parental judgment. The analysis by the

district court and its conclusion is clearly erroneous in that it ignores the great weight which this Court has given in the past to the maintenance of the family structure.

The importance of the family to society has clearly been recognized by this Court in numerous decisions, beginning as long ago as 1923 when, in Meyer v. State of Nebraska, 362 U.S. 390 (1923), the Court prohibited a State's interference with the education and training selected by the family for their children. Soon thereafter this Court reenforced the importance of the family unit in Pierce v. Society of the Sisters, 268 U.S. 510 (1925) in which this Court found that a law requiring children to attend public schools "unreasonably interferes with the liberty of parents and guardians to direct the upbringing and education of children under their control." The Court recognized that "the child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations." More recently, this Court in Wisconsin v. Yoder, 406 U.S. 212 (1972), said, referring to Pierce v. Society of the Sisters, supra, that "as that case suggests, the values of parental direction of the religious upbringing and education of their children in their early and formative years have a high place in our society."

Thus, this Court has recognized, both expressly and implicitly, that the

family is an important social unit in our society and that therefore the family as a social unit is to be valued and protected.

The challenged statute, Ga. Code § 88-503.1(a), here does nothing more than protect the family structure and enable the parents to fulfil the obligation imposed upon them by law to provide for the maintenance and care of their child. The challenged code section supports the family unit by reenforcing parental decisions concerning treatment for their mentally ill children. However, the decision of the district court will prevent the State from supporting parental decisions in this area and will clearly undermine the family structure, pitting the parent and his lawyer against the child and his lawyer in a judicial forum, and in the end substituting a judge for the parents, in order to determine the proper care and maintenance of the child. The spectre of parents and children battling in court to decide issues traditionally reserved to the parents cannot even arguably be said to recognize or support the emphasis placed on the importance of the family by this Court in its earlier decisions.

In view of the digression which the decision of the district court makes from previous statements of this Court's perception of the value of the family, the decision of the district court has raised a substantial question which should be reviewed by this Court and which should result in the reversal of the district court's decis on.

3. If a parent or guardian of a mentally ill child selects, with the assistance of a physician, a State mental health facility as a suitable place for treatment of his mentally ill child, the State should not be prohibited from providing that service to the parent and to the child merely because there might be another "optimally appropriate" treatment setting in which the child could hypothetically be treated.

As an adjunct to its holding that parents or guardians could not admit their minor children to a State mental health facility, the district court also concluded that children for whom mental health treatment is sought, must be treated in a treatment setting most optimally appropriate to the child's condition.

The analysis utilized by the district court in finding the constitutionally demanded answer to the issue, raises a substantial question which warrants review by this Court.

First, the decision of the district court ignores the special status of minors. The mental health code was an attempt to provide mental health services to those who needed it but who were not dangerous or incapable of caring for themselves because of their mental illness. Children could not avail themselves of these services because they were statutorily incapable of consenting to the treatment. Therefore, special provisions were made to allow these children to receive this treatment on a voluntary basis.

To provide for voluntary patients the State has essentially provided one type of facility and has offered its services to the public to accept or reject. The voluntary adult patient does not have standing to argue that the State must furnish him mental health services better than those which he has voluntarily sought, by providing some particular setting which might be "optimally" more appropriate to the patient's situation than a hospital. Neither does the child nor its parents have the right to demand that the State, if it is to provide any mental health services, provide a full range of "optimally appropriate" treatment settings to accommodate every conceivable situation. Georgia law provides that a State mental health facility cannot accept for treatment a child for whom hospitalization is not "suitable." Georgia law does not require and the Constitution of the United States does not mandate that Georgia provide more than that.

Second, the decision of the district court creates an absurd result, allegedly based on constitutional considerations, which will ultimately disrupt the family unit, which this Court has already acknowledged as being worthy of preservation. That is, under the present statutory scheme, an adult who feels that he is mentally ill can seek treatment at the existing mental health facilities and, if he is suitable for treatment, can be admitted to a State hospital and treated for his mental illness. The adult patient

can receive suitable treatment from the hospital even though some other treatment facility might be more optimally appropriate. On the other hand, under the decision of the district court, a mentally ill child in the State of Georgia will not be able to obtain mental health services from the State unless the State happens to have a treatment setting which is optimally appropriate for the child's condition. Thus, if an adult and a child both suffered from the same mental illness and both wished to receive treatment, the adult could receive such treatment in an existing State mental health facility, even if it were not optimally appropriate whereas the child could receive such treatment only if it were determined that the existing facilities constituted the optimally appropriate treatment setting. The result is obviously that some mentally ill children will not receive treatment, which clearly will undermine the family which the State wishes to preserve.

Third, the decision of the district court is erroneous and raises a substantial question because the decision of the district court assumes that children are entitled to the same protected liberty interest which adults are, a conclusion which is not based on any precedent established by this Court. The district court concluded that children have a protected liberty interest and that therefore the principle that any State infringement upon that liberty must be accomplished

in the least drastic manner sufficient to achieve the legitimate purposes of the State. However, the principle of the least restrictive alternative presupposes the existence of an unfettered liberty interest. The molding of that doctrine to the limited and perhaps nonexistant liberty interest of a child is wholly inappropriate. It is evident that this Court has never determined that a child, like an adult, has a right to live without continuous supervision and in fact, this Court has recognized that children are normally in the custody and control of their parents or guardians. See Stanley v. Illinois, 405 U.S. 645 (1972); Pierce v. Society of the Sisters, 268 U.S. 510 (1925).

This Court has recognized that children have always had restrictions imposed by the parents or guardians and that children have never enjoyed the full range of liberties given to adults in our society. Hence, in any treatment setting, as in any other setting where the child might find himself, the child is subjected to the authority of his parents or a person standing in loco parentis. By creating in the child, an unfettered liberty interest and by determining that the child is entitled to the protection embodied in the principle of the least restrictive alternative placement, the district court has laid the foundation for creating a child's right to challenge any decision of his parents which restricts the child in any area which is aided or enforced by any State action. This analysis which establishes the platform on

which the child will be constitutionally entitled to challenge the decisions and commands of his parents clearly ignores the respected position which the family has been given by this Court.

The decision of the district court that persons under 18 years of age are constitutionally entitled to be placed in a treatment facility which is optimally appropriate for their condition and which constitutes the least drastic imposition on the constitutional rights created in the children by the district court, is in error and should be unequivocably rejected by this Court.

CONCLUSION

The district court has through over-reaction created several principles of law which are without precedent and whose impact upon the administration of mental health services to the children of the State of Georgia and upon the family structure will be disastrous.

Those principles will prohibit parents from fulfilling the duties and responsibilities to provide for the care and maintenance of their children and will ultimately prevent the children from obtaining voluntary mental health services in the State of Georgia, a result which cannot be constitutionally demanded, and which must be rejected.

For these reasons, plenary consideration of the judgment below by this Court and its ultimate reversal are warranted.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I, Timothy J. Sweeney, one of the attorneys for Appellants herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served each party in this action with three copies of the foregoing Jurisdictional Statement by depositing three copies of the same in the United States mail, with first class postage prepaid, addressed as follows:

David Goren
Georgia Legal Services Program
653 Second Street
Macon, Georgia 31201

This _____ day of May, 1976.

TIMOTHY J. SWEENEY, Senior
Assistant Attorney General

APPENDIX A

[Filed in Clerk's Office February 26, 1976.
Walter F. Doyle, Clerk]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

J. L. and J. R., minors, individually and as representatives of a class consisting of all persons younger than 18 years of age, now or hereafter received by any defendant for observation or diagnosis and/or detained for care or treatment at any facility within the State of Georgia, pursuant to 1969 Georgia Laws pp. 505-517, informally codified as Georgia Code Annotated § 88-503.1,

Plaintiffs,

- v -

JAMES PARHAM, individually and as Commissioner of the Department of Human Resources, DOUGLAS SKELTON, individually and as Director of the Division of Mental Health and W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital,

Defendants.

CIVIL ACTION
No. 75-163-Mac

Before BELL, Circuit Judge, BOOTLE, Senior District Judge, and OWENS, District Judge.

OWENS, District Judge:

This lawsuit was begun by two boys, one twelve and one thirteen years of age, known herein by their initials—J. R. and J. L.—to secure their release from more than five years of confinement in Georgia's mental hospital at Milledgeville pursuant to Georgia's mental health laws providing for the voluntary admission of minor children to mental hospitals by parents or guardians, to wit: 1933 Ga. Code Ann. §§ 88-503.1, 503.2, 503.3 (1971), [1969] Ga. Laws 505, 517-18:

> "88-503.1 Authority to receive voluntary patients—(a) *The superintendent*[1] *of any facility*[2] *may receive for observation and diagnosis* any individual 18 years of age, or older, making application therefor, *any individual under 18 years of age for whom such application is made by his parent or guardian* and any person legally adjudged to be incompetent for whom such application is made by his guardian. *If found to show evidence of mental illness*[3] *and to be suitable*

[1]Section 88-501 includes the following definition:
" 'Superintendent' shall mean the chief medical officer of any facility receiving patients under the provisions of this Chapter or a physician appointed as the designee of such superintendent."

[2] " 'Facility' shall mean any State-owned or State-operated hospital or other facility utilized for the diagnosis, care, treatment, training, or hospitalization of persons who are mentally ill, any facility operated or utilized for such purpose by the United States Veterans Administration or other Federal agency, and any other hospital within the State of Georgia approved for such purpose by the department." *Id.* at (c).

[3] " 'Mentally ill' shall mean having a psychiatric disorder which substantially impairs the person's mental health." *Id.* at (a). It is interesting to note that the present law adopted a less stringent standard for voluntary admission than previously existed. Under prior law a person could be admitted on a voluntary basis only if "found to be a mentally ill person." [1964] Ga. Laws 499, 532 (§ 88-502), *amending* [1960] Ga. Laws 837, 839. A "mentally ill person" was defined in the 1964 statute as "a person who is afflicted with a psychiatric disorder which substantially impairs his mental health; and because of such psychiatric disorder requires care, treatment, training, or detention in the interest of the welfare of such person or the welfare of others of the community in which such person resides. . . ." [1964] Ga. Laws 499, 530 (Section 88-501(a)). The 1960 definition is substantially the same. [1960] Ga. Laws 837, 838.

> *for treatment, such person may be given care and treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.*" (emphasis added).
>
> "(b) The superintendent of any evaluating facility in the care and treatment of mentally ill per-individual 14 years of age or older who makes application therefor. If such individual is under 18 years of age, his parent or guardian may apply for his discharge and the superintendent shall release the patient within five days of such application for discharge.
>
> "88.503.2. Discharge of voluntary patients.—*The superintendent of the facility shall discharge any voluntary patient who has recovered from his mental illness or who has sufficiently improved that the superintendent determines that hospitalization of the patient is no longer desirable.* He may also discharge any voluntary patient, if to do so would, in his judgment, contribute to the most effective use of the facility in the care and treatment of mentally ill persons: Provided, however, that in no event shall any such patient be discharged if, in the judgment of the superintendent of such facility, such discharge would be unsafe for the patient or others." (emphasis added).
>
> "88.503.3. Right of voluntary patients to discharge on application.—(a) *A voluntary patient* who is admitted to a facility pursuant to section 88-503.1, *or his legal guardian, parent, spouse, attorney or adult next-of-kin, may request his discharge in writing* at

any time after five days following his admission to the facility, excluding Saturdays, Sundays and legal holidays. This request may be submitted to the superintendent or to any staff physician or staff registered nurse of the facility for transmittal to the superintendent. If the patient or another on his behalf makes an oral request for release to any staff physician or staff registered nurse, the patient must, within three days, Saturdays, Sundays and legal holidays excluded, be given assistance in preparing a written request. If a written request is submitted to a staff physician or staff registered nurse, the physician or nurse shall deliver the request to the superintendent within 24 hours. Within five days, excluding Saturdays, Sundays and legal holidays, of the delivery of a written request for release to the superintendent, the patient must be discharged from the facility unless the superintendent finds that the discharge would be unsafe to the patient or others, in which case proceedings for involuntary hospitalization must be initiated under section 88-506.3 prior to the expiration of such five-day period. If the patient was admitted on his own application and the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the agreement of the patient thereto. *If the patient was admitted before the age of 18 on the application of his parent or guardian under section 88-503.1, his discharge prior to becoming 18 years of age may be conditioned upon the consent thereto of his parent or guardian.* If the patient was admitted as an adjudged incompetent on the application of his guardian under section 88.503.1, his discharge prior to a legal restoration of competency may be conditioned upon the consent thereto of his guardian.

(b) Notwithstanding any other provision of this Chapter, *proceedings for the involuntary hospitalization of* an individual received by a facility as a *voluntary patent shall not be commenced unless the discharge of the voluntary patient is first requested as provided in subsection (a)* hereof." (Emphasis added).

J. R. was born on August 14, 1962. Approximately three months after birth a juvenile court because of severe parental neglect, removed him from his parents' home and placed him in a foster home under the supervision of the Georgia Department of Family and Children Services. After having lived in a total of seven different foster homes, when he was almost eight years of age he was admitted by the defendant on June 25, 1970, to Georgia's oldest and largest mental hospital, called Central State Hospital at Milledgeville, Georgia. In each foster home it seemed that he had lost his place to a more favored child. On October 27, 1966, a juvenile court order had given "permanent custody for the purpose of placing said child for adoption"[4] to the Georgia Department of Family and

[4] Georgia's Juvenile Court statute then provided:

"24-2421. Findings, decrees, and orders; probation—When a child is found by the court to come within its jurisdiction, the court shall so decree and in its decree shall make a finding of the facts upon which the court exercises its jurisdiction over such child.

"(2) Upon finding the child to be in a state of neglect, dependency, or living under insufficient and improper guardianship; or to be the subject or controversy as to his legal custody; or to be a person in need of supervision; the court may, by order duly entered, proceed as follows:

"(a) Take custody of the child and place the child under supervision in his own home or in the custody of a suitable person or agency upon such condition as the court shall determine.

"(b) When conditions and circumstances warrant the termination of parental rights, the courts may take custody of the child or children involved for suitable placement or *adoption* and may act in loco parentis in all matters pertaining to their interests. *In such cases the court shall act as guardian of the person and property of the child or children involved.*" Ga. Code Ann. § 24-2421 *repealed and superseded,* Juvenile Court Code, [1971] Ga. Laws 709, Ga. Code Ann. Tit. 24A (1971).

In spite of this court's expressed amazement as to the practice of State departments and officials acting as guardians of minor children

Children Services. Adoption did not materialize, and without further court hearing or order J. R. remained in the custody of the Department of Family and Children Services in said foster homes until that department applied directly to said mental hospital for his admission to said mental hospital pursuant to § 88-503.1. Upon admission he was found by hospital personnel to be mentally ill, and his mental illness was described as "1. Borderline mental retardation 310.90.[5]—2. Unsocialized, aggressive reaction of childhood 308.40".[6] Exhibit 7. In early 1973 hospital personnel began requesting the Department of Family and Children Services to remove J. R. from hospital confinement and place him in a long-term foster or adoptive home because of a feeling that he "will only regress if he does not get a suitable home placement, and as soon as possible." Exhibit 9-A-2. On August 9, 1973, hospital personnel "felt that efforts to obtain a foster placement should be primary at this time, lest [J. R.] become a permanently institutionalized child." Exhibit 10-A-2. A foster home was not obtained for J. R., and he remained in confinement. On October 24, 1975, when this lawsuit was filed, he had been confined for five years and four months of his thirteen years, two months of life.

J. L. at birth on October 1, 1963, was adopted. His parents divorced when he was three, and he went to live with his mother. She remarried and soon gave birth to a

under the challenged statute, the defendants have not yet explained the authority for their doing so. In particular they do not explain how the Juvenile Court's guardianship responsibilities transferred to them without a hearing having been held or court order having been issued.

[5] This nomenclature is derived from the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

[6] *Id.*

child. On May 15, 1970, his mother and step-father pursuant to the previously quoted state law § 88.503.1, applied for his admission to what is now Central State Hospital; he was admitted. Hospital personnel found that J. L. was mentally ill and diagnosed his illness as "Hyperkinetic Reaction of Childhood 308.00."[7] On September 8, 1972, he was discharged to his mother, but she brought him back to the hospital and readmitted him ten days later. He then remained in the hospital in confinement, and at the time this lawsuit commenced had been in confinement for five years and five months of his twelve years, one month of life. In 1973 hospital personnel indicated to the Department of Family and Children Services that J. L. needed to be removed from hospital confinement and placed in specialized foster care. His records show that the Department of Family and Children Services indicated that the department could not pay for institutionalized (private) foster care unless J. L. was eligible for such care to be paid for by A.F.D.C. or Social Security funds. He was not an A.F.D.C. eligible child. See Exhibit 1. Specialized foster care was not obtained for J. L. by the defendants.

J. R. and J. L. filed this lawsuit against defendant James Parham, Commissioner of Georgia's Department of Human Resources which has responsibility for the Division of Mental Health, the Department of Family and Children Services and the Division for Children and Youth;[8] defendant Dr. Douglas Skelton, Director of the Division of Mental Health; and defendant Dr. W. T.

[7] See n. 5.

[8] The Executive Reorganization Act of 1972 transferred these various responsibilities to one department, the Department of Human Resources, 1972 Ga. Laws pp. 1015, 1046.

Smith, Chief Medical Officer of Central State Hospital. In doing so they sought and were allowed to proceed without opposition pursuant to Rule 23, Federal Rules of Civil Procedure, individually and as representatives of the class consisting "of all persons younger than 18 years of age now or hereafter received by any defendant for observation and diagnosis and/or detained for care and treatment at any 'facility' within the State of Georgia pursuant to" the statute identified as § 88.503.1. Court's order of November 17, 1975. Discovery and information furnished by the defendants disclosed that on any given date approximately two hundred children under 18 years of age are confined in one of Georgia's eight mental hospitals pursuant to said law. Deposition of Dr. John Filley p. 64.

~~The~~ plaintiffs filed their complaint against the defendant State officials under 42 U.S.C. § 1983[9] alleging that they and the minor children in the class have been deprived of their liberty without procedural due process of law in violation of the Fourteenth Amendment to the Constitution of the United States which states:

> "Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; *nor shall any State deprive any person of life, liberty, or property, without due process of law;* nor deny to any person

[9] Title 42 U.S.C. § 1983 provides: "Every person who, under color of any statute, ordinance, regulation, custom or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

> within its jurisdiction the equal protection of the laws." (emphasis added).

They contend their constitutional rights are violated by the operation of the statutory scheme by which they have been and are being involuntarily confined in state mental hospitals "without being afforded a meaningful and complete opportunity to be heard," and further, by which they are incarcerated "without initial and periodic consideration of placement in the least drastic environment." Complaint at 9. Plaintiffs also contend that this statute unconstitutionally permits parents and guardians and defendants to cause their involuntary commitment to state mental hospitals under the guise of a "voluntary" procedure. They do not constitutionally attack, and this court is not called upon to approve or disapprove of this statute's requisite standard for voluntary treatment of the mentally ill—"If found to show evidence of mental illness and to be suitable for treatment. . ." § 88-503.1(a).

Plaintiffs prayed for a declaratory judgment, an injunction and damages and asked that a district court of three judges be convened pursuant to 28 U.S.C. § 2281 and 2284 to hear and determine their prayer for an injunction to restrain the operation of this state statute. On November 5, 1975, this district court of three judges was designated and composed.

The defendants assert that Georgia's voluntary admissions statute rather than being state action unconstitutionally depriving the plaintiffs of their liberty, is a system of mental health care designed and offered by the state as *parens patriae*[10] to parents to assist them in their tradi-

[10] *Parens patriae* means "Father of his country; parent of the country. In England, the king. In the United States, the state, as a sovereign—

tional parental duty of providing for the "maintenance, protection and education of their children." 1933 Ga. Code Ann. § 74-105. Moreover, the hospitalization of the plaintiffs is merely the acceptance by the parent for his child of the state's designed and offered mental health care system. They go on to suggest that a child is constitutionally protected (a) upon admission by his parents and the professional psychiatric judgment of defendants and the other doctors and personnel of Georgia's eight mental hospitals and (b) during hospitalization by the ever-present parental interest and/or the statutory command that "the superintendent of the facility *shall discharge* any voluntary patient who has recovered from his mental illness or who has sufficiently improved that the superintendent determines that hospitalization is no longer desirable. . . ." § 88-503.2. The plaintiffs, they say, have shown no compelling reason for interference with this statutorily fostered relationship between the parent, his child and psychiatric and other professional staff of Georgia's mental health system.

The court convened on November 19, 1975, and heard from the parties. More than twenty depositions of lay and expert witnesses have been taken; hospital records and statistical evidence have been produced. The attorneys for each side have adequately and fully briefed the issues. *Amicus* the National Juvenile Law Center, St. Louis University School of Law and the Child Advocacy Project of the American Civil Liberties Union Foundation of Georgia, Inc. have also submitted extensive briefs. On two sep-

referring to the sovereign power of guardianship over persons under disability: In re Turner, 94 Kan. 115, 145 P. 871, 872, Ann. Cas. 1916E, 1022; such as minors, and insane and incompetent persons; McIntosh v. Dill, 86 Okl. 1, 205 P. 917, 925." Black's Law Dictionary, Revised Fourth Edition, p. 1269.

arate occasions the three judges of this court have visited two of Georgia's eight regional mental hospitals—Central State Hospital at Milledgeville, and Atlanta Regional Hospital at Atlanta—and witnessed for themselves the facilities in which plaintiffs are confined. During those visits the court talked at length with the defendants, hospital personnel and some of the plaintiffs. No further hearings are deemed necessary and the case is now ready for decision.

JURISDICTION

The court has jurisdiction of plaintiffs' complaint filed pursuant to 42 U.S.C. § 1983, under 28 U.S.C. § 1343 (3), 2201 and 2202. The prayer for injunctive relief restraining the operation of the allegedly unconstitutional state statute by defendant state officials is required to be heard by a district court of three judges. 28 U.S.C. § 2281, 2284.

THE FACTS

The State of Georgia through its Department of Human Resources now provides a comprehensive state-wide program of treatment services for mentally ill children and adults at public expense. Out-patient services are rendered at approximately fifty community mental health centers serving children and adults. In-patient, confinement care is provided in eight regional hospitals[11]—seven of which

[11] The eight regional hospitals and their first year of operation are:

Central State, Milledgeville	1842
Southwestern, Thomasville	1966
Georgia Mental Health Institution, Atlanta	1965
Atlanta Regional	1968
Augusta Regional	1969
Savannah Regional	1970
Northwest Georgia, Rome	1975
West Central Georgia, Columbus	1974

were opened within the last ten years—located in Atlanta, Milledgeville, Rome, Savannah, Thomasville, Augusta, and Columbus.

The magnitude of Georgia's program for the mentally ill is demonstrated by the fact that for fiscal year 1976, of the legislature's total appropriation of $379,030,100.00 state money for the Department of Human Resources, $121,106,626.00 is expressly budgeted for out-patient and in-patient mental health[12] services. In addition the state received and spent $28,685,233.00 federal and other money for these services. $149,791,859 was thus expended for mental health care in this state in one year.[12a]

At the end of 1969 a total of 10,643[13] mentally ill persons were confined in this state's mental hospitals; in addition some 1,864 persons were in state institutions for the mentally retarded. According to the defendants, 7,523 mentally ill and mentally retarded persons were in confinement at the end of 1975.

Children under 18 years of age are cared for as both out-patients and in-patients. In fiscal year 1974 more than 5,596 children received out-patient mental health services and 812 were admitted as mentally ill in-patients. Of these 812 children, 515 were admitted by their parent or guardian, or the defendants as custodians, pursuant to the voluntary admissions statute herein attacked, and 297 were involuntarily or court committed. Figures furnished by

[12] These totals exclude the Georgia Retardation Center and Gracewood State Hospital which serve only the mentally retarded. Since services for mentally retarded are not completely separated from those for the mentally ill, these figures do include all other services for the mentally retarded.

[12a] Source: State of Georgia Budget Report Fiscal Year 1977, Vol. I.

[13] Statistical Abstract of the United States, 1972.

the defendants show the following admissions of mentally ill children as in-patients:

Fiscal Year	Voluntary	Percentage	Involuntary	Percentage
1969	50	35%	94	65%
1970	84	65%	46	35%
1971	131	82%	28	18%
1972	246	74%	88	26%
1973	458	72%	181	28%
1974	515	63%	297	37%
1975	445	58%	317	42%
1976	110	65%	60	35%
	2,039	65%	1,111	35%

While Dr. Filley has testified (Deposition, p. 64) that usually on any given day some two hundred children are in the state's eight regional mental hospitals as voluntary admittees, actual figures furnished[14] for October 31, 1975,

[14] Members of Plaintiff Class—October 31, 1975

Hospital	Total children confined	Average time of confinement	Minimum time of confinement	Maximum time of confinement
Southwestern at Thomasville, Ga.	10	100 days	17 days	397 days
Central State at Milledgeville, Ga.	37	456 days	22 days	2,035 days
Atlanta Regional at Atlanta, Ga.	21	161 days	6 days	730 days
Georgia Mental Health Institute at Decatur, Ga.	26	346 days	18 days	1,244 days
Augusta Regional at Augusta, Ga.	14	92 days	13 days	261 days
Savannah Regional at Savannah, Ga.	16	127 days	15 days	165 days
West Central at Columbus, Ga.	16	71 days	26 days	179 days
TOTALS	140	249.9 days	6 days	2,035 days

(Source—December 19, 1975, affidavit of Cynthia Arnold, a Secretary for Division of Mental Health and Mental Retardation, Department of Human Resources)

show that 140 children were confined on that day as voluntary admittees (and are members of the plaintiff class) and had then been confined for an average time of 249.9 days. The minimum time of confinement was 6 days and the maximum time was 2,035 days, almost six years.

The approximately 200 plaintiff class minor children are emotionally disturbed, non-psychotic[15] children in need of other than out-patient, community mental health clinic care. For their care the State affords only confinement or detention in one[16] of Georgia's eight regional mental hospitals.

Defendant Parham as Commissioner of the Department of Human Resources also has responsibility for a division known as "D.F.A.C.S." or Division of Department of Family and Children Services. That division administers to needy families and children, both those eligible for A.F.D.C. or social security funds and others. The division of mental health can and does request the "D.F.A.C.S." to make arrangements for children to be removed from one of the regional mental hospitals and placed in a foster home or a specialized foster home. The term foster home means private citizens who volunteer for nominal compensation ($3.40 to $4.45 per day per child) to keep children in their home. As volunteers they keep only those children they want to keep and keep them only as long as they want

[15] Psychotic is synonymous with *insane, lunatic, mad, crazy*—Reader's Digest Family Word Finder, 1975.

[16] The defendants have regionalized Georgia's mental hospitals for the purpose of locating patients near their homes and loved ones, so that their family and friends can visit and assist in the treatment program. The court notes that this plan is not uniformly administered by the defendants—one of the named plaintiff under the plan should be at Georgia Mental Health Institute instead of at Central State Hospital. This may signal a need for mandatory policies, rules and regulations.

to. Specialized foster homes are foster home parents who agree to keep one or two children who are in need of individual, special care and attention. An additional compensation of $125.00 per month, plus $1.75 per child per day is paid. The division now has some 3,700 children in foster homes and space for some 26 children in 13 specialized foster homes. Seven additional specialized homes have been budgeted for several years, but no volunteer parents have appeared. The evidence shows that no organized effort and very little, if any, other effort has been made by the defendants to establish these 7 specialized foster homes.

In early 1973, a Study Commission on Mental Health Services for Children and Youth was formed at the request of Dr. Gary E. Miller, then Director of the Division of Mental Health. After a SIX MONTHS study of the then five regional hospitals, the eight members [17] reported many things in their November 9, 1973, detailed account, among which are:

> "1. Children and Youth are *still dependent,* living and growing under the auspices of others, dependent upon someone else for their psychological maturation and their material and physical well-being.
>
> "A child is dependent upon someone else for identifying his need for help and in seeking assistance. There-

[17] The members were: Marquis C. Baeszler, ACSW, Director, Children's Program, Clayton County CCMHC: Norbert Enzer, M.D., Professor and Chairman, Department of Psychiatry, Michigan State University; James C. Flanagan, M.D., Atlanta; Barbara Harvey, R.N., Division of Mental Health, Georgia Department of Human Resources; J. I. Riddle, M.D., Director, Western Carolina Center, Morganton, N. C.; William W. Swan, Ed.D., Coordinator of Evaluation, Technical Assistance for Psychoeducational Centers, Athens; Richard S. Ward, M.D., Emory University School of Medicine; Mary M. Wood, Ed.D., University of Georgia.

fore, there are no true 'voluntary' child admissions, and criteria must be established to protect children from needless institutionalization or from the assumption that every child in crisis needs service at a regional hospital."

(Report of Commission at 6).

* * *

"4. Children learn from their environment and adapt themselves to it. Such adaptation usually becomes an integral part of the child's personality. A child institutionalized for long periods of time may learn and assimilate 'institutionally appropriate' behavior which in turn is an additional handicap if he is to return to his normal environment. Therefore, all forms of 24-hour care should simulate a *normal childhood environment* to the extent possible and should maintain regularly scheduled home visiting from the time of initial admission.

"5. While certain children do require long-term institutional care, it is extremely important that they receive continued evaluation and reappraisal so that they can be provided alternative forms of care at an optimal time. Therefore, it is imperative that appropriate discharge placement plans be started at the time of admission; this, of course, presupposes a variety of community facilities."

(Report of Commission at 7).

* * *

"The commission suggests that State improvement of mental health services to children and youth is urgently needed.

"[I]t is very difficult to estimate the needs of mental health services for children and youth in Georgia for a number of reasons:

1. There are no established State program standards.

2. There is no State plan for mental health services to children and youth. There is no data collection system describing present services for children and youth as a basis for intelligent planning.
3. There are so few appropriate services that recommendations for length of treatment, required 'bed space', and alternative services can only be educated guesses. In most of Georgia, for a disturbed child or youth, there are only two sources of service—a Youth Development Center or a Regional Mental Hospital. It is clear that not all disturbed children benefit from either of these types of programs."

(Report of Commission at 9, 10).

* * *

"The commission supports the position of a majority of professionals involved in child and youth treatment that there are many alternative forms of both 24-hour care and community-based out-patient care which are preferable alternatives to hospitalization yet, which, with a few notable exceptions, do not exist at present in Georgia."

(Report of Commission at 11).

* * *

"IT IS THE OBSERVATION OF BOTH HOSPITAL PERSONNEL AND THE COMMISSION THAT MORE THAN HALF OF THE HOSPITALIZED CHILDREN AND YOUTH WOULD NOT NEED HOSPITALIZATION IF OTHER FORMS OF CARE WERE AVAILABLE IN COMMUNITIES."

(Report of Commission at 24).

* * *

"II. *Variations of 24-hour care not requiring a hospital:*

a. *Small group crisis home:* up to eight children served in a home for temporary or intensive care; psychiatric and nursing services available; admission to crisis home is on a short-term basis and patient turnover is fairly rapid (eight weeks or under).

b. *Small group home:* up to eight children requiring a different living situation but not in need of having a specialized treatment environment; psychiatric and nursing care services available on a consultative (or on-call) basis.

c. *Specialized small group living home:* designed for children needing long-term care of a specialized nature; this varies from the specialized psychiatric hospital in that the program is conducted in a small group home with not more than six children.

d. *Small group home clustering:* by clustering a number of small group homes in close proximity, it is possible to provide more effective psychiatric and nursing care to a greater number of children; such closeness provides for easy patient movement from home to home; i.e., from a crisis home to a small group, non-crisis home.

e. *Therapeutic camp life:* generally used for intensive or extended treatment; allows children to participate in a therapeutic environment in a primitive but wholesome setting; psychiatric services available.

f. *Specialized foster parent program:* foster families selected to provide specialized foster care to disturbed children; such parents would be assisted through on-going instruction from mental health workers in therapeutic management of their disturbed foster children; a variation of this program would be specialized foster parents for weekends only, thereby providing a hospitalized child without a family a weekend home program.

g. *Rotating parent program:* parents to children in treatment share in the care of each other's children on daily, weekend, or weekly basis; such a program often provides intermittent relief for parents without having to hospitalize the child. The State should compensate the participating parent on an hourly basis.

h. *Home care services:* mental health treatment team (based in community or hospital) visits the child's home on a weekly basis, or more frequently if needed, in order to assist the parents in home management; in this way parents are taught treatment procedures and effective management while the child lives at home.

i. *Private child care agencies:* an arrangement whereby the State purchases care at numerous private child care agencies on a temporary, intensive, or extensive basis at private facilities providing 24-hour child care and treatment services, when families are not able to purchase services privately and the needed services are not available at public facilities."

(Report of Commission at 26, 27).

* * *

"ADMISSION GUIDELINES FOR CHILDREN AND YOUTH TO STATE HOSPITALS NEED TO BE MORE SPECIFIC.

*** In particular, the commission stresses the need to protect children and youth from being inappropriately admitted to state hospitals, and guidelines are needed for assisting admissions staff in determining appropriate alternative services."

(Report of Commission at 51, 52).

* * *

"THE MENTAL HEALTH LAWS OF GEORGIA SHOULD BE REVIEWED WITH SPECIFIC REFERENCE TO THE RIGHTS OF CHILDREN AND YOUTH."
(Report of Commission at 60).

The Department of Human Resources in the more than two years since said detailed, more than 100 page report, has not endeavored to provide forms of care other than hospital confinement. Foster homes and specialized foster homes are in existence, but foster home parents generally don't accept these problem, emotionally disturbed and/or adolescent children. In addition, only 13 specialized foster homes with a capacity of two (2) children each, are in existence in this entire state.

In an appendix to its report the said study commission summarized the strengths and weaknesses at the then five hospitals. Note the following:

"(c) *type of children served at regional hospitals:* at three of the five regional hospitals the staff reports that a *majority of the children need not be hospitalized* if alternative services were available in the community. At the other two hospitals the staff reported that the *length of stay could be significantly reduced* if there were adequate follow-up services. (italics supplied).

Between 50-75% of children served in these institutions have no family or are part of severely dysfunctional family units (e.g., DFCS custody).

More than 50% of children served are characteristically aggressive, anti-social, hyperkinetic or runaways, and non-psychotic. The child and youth population of the regional hospitals in

many respects is similar to those identified as youthful offenders, except they have not been sentenced."

(Report of Commission, Appendix at A-5, 6).

Are there now members of the plaintiffs' class in need of care other than in a mental hospital? In response to this question the defendants by letter dated January 24, 1976, submitted a list of hospitalized, plaintiff children compiled by the staff personnel of each regional hospital in response to a request "to designate the situation in which they would like to see the child placed in order to get optimal benefits." That list as of January 19, 1976, shows 46 children[18] who could be optimally cared for in another, less restrictive, non-hospital setting if it were available.

[18] That list shows:

Hospital	Initial	Age	ID #	Optimal Alternative Care Recommended
Savannah	P. J.	15	11-7881	Group Home
	B. B.	16	15-9299	Group Home
	T. J.	14	11-1857	Group Home
	J. L.	13	98-1131	Group Home
	J. K.	15	00-1063	Group Home
	J. J.	9	00-1872	Foster Care
	S. M.	13	98-6034	Group Home (MR)
Southwestern	P. S.	12	64-93	Group Home
	B. B.	10	63-66	Specialized Foster Home
GMHI (Children)	L. E.	13	01-3487	Residential Treatment
	J. A. F.	11	01-3768	Specialized Foster Care or Group Home
	H. K.	10	00-9480	Group Home
	D. D.	13	01-2938	Group Home (MR)
	R. W.	10	01-5832	Group Home
	J. F.	12	01-5326	Group Home
GMHI (Adolescent)	D. P.	16	01-1334	Residential Treatment
	M. W.	14	01-3434	Residential Treatment
Central	J. L.	12	172-897	Specialized Foster Care
	T. L.	12	191-700	Specialized Foster Care
	J. R.	13	173-617	Specialized Foster Care or Group Home

Children eligible for A.F.D.C. or social security federal money are placed in privately operated, less restrictive settings. These 46 children are not eligible for such

[18] (Continued)

Hospital	Initial	Age	ID #	Optimal Alternative Care Recommended
Central (Cont'd)	S. S.	11	205-397	Specialized Foster Care
	M. B.	15	207-053	Specialized Foster Care or Group Home
	S. B.	15	206-001	Specialized Foster Care
	J. C.	15	196-470	Specialized Foster Care (In Rome Hospital)
West Central	T. L.	12	17-1093	Group Home
	C. H.	12	94-9963	Group Home
	W. W.	8	000-362	Group Home
	T. B.	15	000-227	Group Home
	T. D.	10	13-4127	Specialized Foster Care
Augusta	L. O.	12	15-8483	Group Home
	J. D.	14	00-2264	Group Home
	A. H.	6	00-2859	Specialized Foster Care
	M. S.	8	00-2637	Specialized Foster Care
Atlanta	W. B.	16	02-9667	Residential Treatment
	L. W.	16	96-6716	Residential Treatment
	M. H.	14	00-3853	Residential Treatment or Specialized Foster Care
	D. D.	13	00-3714	Residential Treatment
	C. B.	13	00-3666	Structured Adolescent Day Program for MR
	J. H.	9	00-3575	Residential Treatment
	T. P.	9	00-3452	National Jewish Hospital, Denver, Colorado (Program for emotionally disturbed children with an asthmatic program)
	(Hospitalization needed unless mother will apply for admission to National Jewish Hospital)			
	H. T.	16	94-5967	Residential Treatment or Specialized Foster Care
	M. M.	10	00-4199	Group Home or Specialized Foster Care
	P. B.	10	15-5190	Specialized Foster Care
	W. H.	11	17-7859	Residential Treatment
	E. D.	16	00-4320	Specialized Foster Care or Group Home
	R. S.	13	01-4267	Specialized Foster Care or Residential Treatment

federal money, and for them the State affords nothing other than hospitalization.

In exploring the lack of alternative care for these minor children the court was advised by the defendants that it costs approximately $40,000.00 per child per year to care for a child confined in one of Georgia's regional mental hospitals. The court has also been advised that a special group home operated by employees of the Department of Human Resources, Division of Mental Health, can accomodate and care for eight children and would cost $60,000.00 per year to operate—$7,500.00 per year per child.

For fiscal year 1966 the State budgeted some $1.9 billion and for fiscal year 1977 the Governor has recommended a budget of $1.922 billion. The court asked defendants to meet with the Governor and the Chairmen of the Appropriations Committees of the House and Senate to determine whether or not appropriated funds of $180,000.00 to open three [19] group homes for these children could be immediately made available. Defendant Dr. Skelton following a January 15, 1976, meeting responded:

"8.

"The Governor and Chairmen of the respective Appropriations Committees concluded that because of (1) the current state of the economy, (2) the necessity for adopting an austerity budget, (3) the inability of the State to afford new programs, (4) *their opinion that the regional hospitals were offering appropriate treatment for children,* and (5) the existence of more critical unmet needs, $60,000 could not be added to the 1976 budget nor $180,000 to the

[19] At that time the defendants advised that 23 children were suitable for group homes of 8 children each.

1971 budget for three group homes for twenty-three (23) mentally ill children presently hospitalized." (italics supplied).

"9.

"The Governor also determined that emergency funds were not available for new group homes for children.

"11.

"Departments were instructed by the Governor to plan for an increase in operational budget for fiscal year 1977 of only 1.9%. Such a small increase does not permit the addition of new programs unless absolutely essential." (Affidavit of Dr. W. Douglas Skelton).

The fiscal year 1977 budget of the Department of Human Resources as recommended by the Governor includes $1,779,000 for group homes/foster grandparents program for the mentally retarded—plaintiffs are not in the mentally retarded group—and $1,900,000 in the Governor's Emergency Fund.[20]

[20] See n. 12a.

THE DUE PROCESS CLAUSE

and

ITS APPLICATION TO JUVENILES

Section 1 of the Fourteenth Amendment as here applicable states:

> ". . . No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

Proposed to the States by Congress on June 13, 1866, this amendment had been ratified by them on July 21, 1868. As the Supreme Court said in 1876:

> "While this provision of the Amendment is new in the Constitution of the United States as a limitation upon the powers of the States, it is old as a principle of civilized government. It is found in Magna Charta, and, in substance if not in form, in nearly or quite all the constitutions that have been from time to time adopted by the several States of the Union. By the 5th Amendment, it was introduced into the Constitution of the United States as a limitation upon the powers of the National Government, and by the 14th, as a guaranty against any encroachment upon an acknowledged right of citizenship by the Legislatures of the States." *Munn* v. *People of Illinois*, 1876, 94 U.S. 123, 24 L. Ed 77, 83, 4 Otto 123.

Called upon in innumerable cases to determine what adult persons are protected by the guaranties of this amendment, it nevertheless was ninety-one years before the Supreme Court was first called upon to decide whether or not this guaranty against encroachment, this "due pro-

cess of law is requisite to the constitutional validity of proceedings in which a court reaches the conclusion that a juvenile has been at fault, has engaged in conduct prohibited by law, or has otherwise misbehaved with the consequence that he is committed to an institution in which his freedom is curtailed." *In re Gault,* 1967, 387 U.S. 1, 12, 18 L.Ed 2d 527, 537, 87 S.Ct. 1428. In answering that question the Court stated:

> "This Court has not heretofore decided the precise question. In Kent v. United States, 383 US 541, 16 L ed 2d 84, 86 S. Ct 1045 (1966), we considered the requirements for a valid waiver of the 'exclusive' jurisdiction of the Juvenile Court of the District of Columbia so that a juvenile could be tried in the adult criminal court of the District. Although our decision turned upon the language of the statute, we emphasized the necessity that 'the basic requirements of due process and fairness' be satisfied in such proceedings. Haley v. Ohio, 332 US 596, 92 L ed 224, 68 S Ct 302 (1948), involved the admissibility, in a state criminal court of general jurisdiction, of a confession by a 15-year old boy. The court held that the Fourteenth Amendment applied to prohibit the use of the coerced confession. Mr. Justice Douglas said, 'Neither man nor child can be allowed to stand condemned by methods which flout constitutional requirements of due process of law.' To the same effect is Gallegos v. Colorado, 370 US 49, 8 L ed 2d 325, 82 S Ct 1209, 87 ALR2d 614 (1962). Accordingly, while these cases relate only to restricted aspects of the subject, they unmistakably indicate that, whatever may be their precise impact, *neither the Fourteenth Amendment nor the Bill of Rights is for adults alone." Id.* at 12; 538. (Emphasis added).

So it is that it is now firmly established[21] that all persons—children and adults—are protected by the prohibitions of the Fourteenth Amendment.

The breadth and scope of these constitutional rights is a more difficult question for the resolution of which it is appropriate in the beginning to consider the history and background of the statute herein attacked. First, the history as found in *Lessard* v. *Schmidt,* 349 F.Supp. 1078, 1084 (E.D. Wisc. 1972):

> "The common law had little need to concern itself with questions of adequate procedure for involuntary confinement because public institutions for the mentally ill were virtually nonexistent. *See* 1 Blackstone, Commentaries 305 (Christian ed. 1827). In the colonies, parents and family were expected to care for their own mentally disabled. S. Brakel & R. Rock, The Mentally Disabled and the Law 4 (1971 ed.) [hereinafter cited as Brakel & Rock]. The first mental hospital in the United States was not established until 1751, with few additional institutions being built until the middle of the nineteenth century. As a result of the lack of facilities and limited medical knowledge of methods of treatment, those confined were generally clearly deranged and violent. Brakel & Rock, *supra,* at 5. A New York statute, enacted in 1788, distinguished between the 'furiously madd' who were 'so far disordered in their senses that they may be dangerous to be permitted to go abroad,' and who could be confined upon the issuance of a warrant by two or more justices, and other 'lunatics' who could be taken under the care and protection of

[21] *See, e.g.,* Breed v. Jones, — U.S. —, 95 S.Ct. 1779, 44 L.Ed 2d 346 (1975); Goss v. Lopez, 419 U.S 565, 95 S.Ct. 729, 42 L.Ed 2d 725 (1975); *In re* Winship, 397 U.S. 358, 90 S.Ct. 1068, 25 L.Ed 2d 368 (1970); Tinker v. Des Moines Community School District, 393 U.S. 503, 89 S.Ct. 733, 21 L.Ed 2d 731 (1969); Levy v. Louisiana, 391 U.S. 68, 88 S. Ct. 1509, 20 L.Ed 2d 436 (1968).

friends and relatives. N.Y. Laws of 1788, ch. 31. Under these circumstances, few questions were likely to be raised regarding improper commitment.

"Gradually, as more asylums were built, the number of persons committed increased, and confinement was not limited to the obviously dangerous. The change in attitude was reflected in the courts. In 1845, an inmate of a Massachusetts institution for the insane brought a habeas corpus action, alleging that his commitment was illegal. Matter of Josiah Oakes, 8 Law Rep. 123 (Mass. 1845). The Massachusetts Supreme Court held that

> " 'the right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others. . . . And the necessity which creates the law, creates the limitation of the law. The questions must then arise in each particular case, whether a patient's own safety, or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto. The restraint can continue as long as the necessity continues. This is the limitation, and the proper limitation.'

Id. at 125. Dangerousness to self thus became an additional criterion upon which commitment could be based. This criterion apparently rested on an assumption that a state could proceed as *parens patriae* to protect the interests of the person involved. The doctrine could be justified as a derivation of an English law, under which the King was appointed the guardian of the person and goods of a lunatic. A person found to be a lunatic was committed to the care of a friend who received an allowance with which to care for the unfortunate person. During 'lucid moments'

the incompetent was permitted to manage his own property, and to generally exercise his civil rights. He was also entitled to an accounting from the King. There was thus a very real difference between the English practice, which could only be for the benefit and protection of the incompetent, and which was only effective during periods of insanity, and the American innovation, which resulted in total, and perhaps permanent, loss of liberty."

(footnotes omitted).

THE DEVELOPMENT of GEORGIA'S MENTAL HEALTH LAWS

Prior to the 1969 complete revision of Georgia's mental health laws,[22] proceedings to involuntarily commit a person to a mental hospital were conducted by a "lunacy commission", usually composed of two physicians and a lawyer, appointed by the ordinary.[23] The decision of the commission could be appealed to the superior court where a jury trial was available.[24]

The first authorization for a "lunacy commission" came in 1834 when the legislature established a procedure for the ordinary to appoint a guardian for any person found to be mentally incompetent by a commission of 12 persons, including one physician, appointed by the ordinary.[25] The appointment of a guardian was a significant step because guardians were authorized to confine wards in an asylum "if necessary for their own protection or the safety of others."[26] By 1872 the jurisdiction of the commission had been enlarged to cover commitment of citizens to the lunatic asylum.[27] Other than a change in the make-up of the commission to two doctors and a lawyer in 1918,[28] and procedural refinements relating to notice and the right of the alleged incompetent to counsel,[29] this basic scheme[30]

[22] The adoption of present Ga. Code Ann. ch. 88-5, 1969 Ga. Laws 505.
[23] 1933 Ga. Code § 49-604, *as amended* 1964 Ga. Laws 499, 534, *repealed* 1969 Ga. Laws 505, 541.
[24] *Id.* § 49-606.
[25] Act of 1834, 1 Cobb's 1851 Digest 343, *as amended* Act of 1835, 1 Cobb's 1851 Digest 345, *codified* 1863 Ga. Code §§ 1806-08.
[26] 1863 Ga. Code § 1814.
[27] 1872 Ga. Code § 1855.
[28] 1918 Ga. Laws 162.
[29] *e.g.*, 1964 Ga. Laws 499, 534-37.
[30] *codified* in 1933 Ga. Code § 49-604, *as amended* 1964 Ga. Laws 499, 534.

existed until the present procedures were adopted in 1969. 1969 Ga. Laws 505.

The ordinary in 1872 also acquired the power, exercised by the inferior courts[31] prior to their abolition by the Constitution of 1868, to commit insane persons to the asylum when such persons "for public safety, or other good and sufficient reason, should no longer be left at large."[32] Acting under this authority, the ordinary could summarily commit persons alleged to be dangerously insane without resort to a lunacy commission.[33] This provision likewise survived into the 1933 code, 1933 Ga. Code § 49-612, *as amended* 1950 Ga. Laws 30, 31, and remained as law until its 1969 repeal.[34]

Judicial commitment, however, has not been the only method of civil hospitalization. In 1857 the legislature provided for the admission of a person to the hospital provided (1) that he did not complain and did not request a jury trial, (2) that someone was willing to pay his expenses, and (3) that evidence of insanity was provided by the certificate of three physicians.[35] The provision, first codified in 1863 Ga. Code § 1297, was carried through subsequent codifications, *e.g.*, 1933 Ga. Code § 35-228, and remained available until its repeal by 1960 Ga. Laws 837.

The first provision for truly voluntary admission to a mental hospital—and the first statute to make special pro-

[31] 1863 Ga. Code § 1815, *as amended* 1866 Ga. Laws 22.
[32] 1872 Ga. Code § 1864. *See* Strickland v. Peacock, 209 Ga. 773, 778, 77 S.E. 2d 14 (1953).
[33] *See* Dickinson v. Hicks, 160 Ga. 487, 128 S.E. 770 (1925); Reagan v. Powell, 126 Ga. 89, 53 S.E. 580 (1906).
[34] 1969 Ga. Laws 505.
[35] 1857 Ga. Laws 123.

vision for children—came in 1952. The legislature in that year authorized the admission of

> "any individual who is mentally ill or has symptoms of mental illness, and who, being sixteen years of age or over, applied therefor, and any individual under sixteen years of age who is mentally ill or has symptoms of mental illness, if his parent or legal guardian applied therefor in his behalf. . . ." 1952 Ga. Laws 94, 95.

Admission under this statute was conditioned on the payment of expenses by the patient or someone acting on his behalf.[36]

Superseding this statute in 1960 was 1960 Ga. Laws 837, which provided that any person 18 years of age or older who voluntarily applied, or any person less than that age whose parent or guardian applied, could be admitted for "observation and diagnosis" without any requirement that mental illness or evidence of such be shown. Detention for "care and treatment" was to be given if the admitted individual was "found to be a mentally ill person."[37] Substantially similar voluntary provisions were retained in 1964 when Georgia comprehensively revised its public health laws, 1964 Ga. Laws 499, 532 (§ 88-502), and remained in effect until the present provisions were enacted in 1969.[38] A significant change in the law between 1964 and 1969 is that the 1969 statute authorizes detention for treatment if the admitted individual is found "to show evidence of mental illness,"[39] whereas the 1964 statute authorized detention of an admitted individual if he was "found to be a mentally ill person."[40]

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[36] 1952 Ga. Laws at 95.
[37] 1960 Ga. Laws at 839.
[38] 1969 Ga. Laws 505, 517, Ga. Code Ann. § 88.503.1.
[39] Ga. Code Ann. § 88.503.1, 1969 Ga. Laws 505, 517.
[40] 1964 Ga. Laws 499, 532 (§ 88-502).

GEORGIA'S STATUTORY SCHEMES FOR THE MENTALLY ILL

It is also appropriate to more fully examine Georgia's entire statutory scheme for the hospitalization of the mentally ill.

A. HOSPITALIZATION OF THE MENTALLY ILL.

As enacted by 1969 Ga. Laws 505 and informally codified as 1933 Ga. Code Ann. 88-5, Georgia's statutory scheme provides first that "the policy of the State is that no person shall be denied care and treatment for mental disorder . . ." § 88-505.2, and "each patient in a facility and each person receiving services for mental disorders shall receive care and treatment that is suited to his needs . . ." § 88-502.3(a).

Authority is first given for the voluntary admission of minors, adults and those already adjudged to be incompetent. Those sections—88-503.1 through 88-503.3— already quoted, are partially herein attacked.

For involuntary commitments there are provisions for judicial admissions of "a person . . . if he is mentally ill, and he is (a) likely to injure himself or others if not hospitalized or (b) incapable of caring for his physical health and safety." § 88-507.1. A petition alleging these criteria supported by a physician's statement of examination within the preceding five days and that said criteria are met, is filed in the court of ordinary. § 88-507.2. The alleged incompetent designates his own representative and the court selects a second representative from the following: "legal guardian, spouse, an adult child, parent, at-

torney, adult next-of-kin, or adult friend." Finding none, a guardian ad litem is appointed. § 88-507.3. Such appointments automatically expire after 90 days or lesser stated time. § 88-502.19. The court issues a commission to two physicians and a lawyer to examine the patient and report to the court as to his mental condition and need for hospitalization. The proposed patient is entitled to counsel; for indigents counsel is appointed and paid by the court. Within five days and after written notice the court presides over a hearing with the commissioners present for the purpose of the commission receiving evidence. Within five days thereafter the commissioners file a written report. If the report is a unanimous finding of the said criteria, the court orders hospitalization in a treatment facility, a regional hospital. § 88-507.3. An appeal lies to the superior court where the issue is submitted to a jury. § 88-502.16. The order of hospitalization authorizes retention of the patient for six months. § 88-507.3(j). If the superintendent believes hospitalization beyond six months is necessary, he must petition the court of ordinary for an order. The petition is served on the patient and his representatives. It includes notice of right to appointed counsel and to a hearing if requested. If no hearing is requested, the court of ordinary may order retention for an additional period not to exceed one year. If a hearing is requested, the hearing examiner holds an evidentiary hearing, and if he concludes that continued hospitalization is required, he orders it "and the treatment facility shall thereby be authorized to retain the patient for a period not to exceed one year." § 88-506.6. Appeals from such orders lie to the superior court. § 88.506.5.

Where the governing authority of the county authorizes its use, optional medical admissions procedures for in-

voluntary commitment under the same criteria, may be utilized. A person may be admitted to an emergency receiving facility upon a physician's certificate or order of the court of ordinary. § 88-504.2. He is there examined and within 24 hours released or transported to an evaluating facility. § 88.504.4. The evaluating facility—one of Georgia's regional mental hospitals—within five days must release him or initiate proceedings for involuntary hospitalization under § 88-506.3. That section permits hospitalization upon recommendation of the superintendent supported by the opinions of two examining physicians that the statutory criteria are met. Notice is given to the patient and his representatives of his right to apply immediately to the court of ordinary for appointment of counsel and for a hearing. If no hearing is requested, the patient may be retained for six months. If a hearing is requested, the court of ordinary holds it within five days and after hearing evidence determines whether or not the statutory criteria are met. If so, hospitalization may continue for six months. §§ 88-506.3 and 88-506.4. The remainder of the statutory procedure is thereafter as already described.

B. THE JUVENILE COURT CODE OF GEORGIA.

Following the Supreme Court's decision in *In Re Gault*, 387 U.S. 1, 87 S.Ct. 1428, 18 L.Ed 2d 527 (1967) Georgia's then existing juvenile court laws were examined with a view of engrafting adult due process requirements into such procedures. As a result Georgia enacted a completely revised Juvenile Court Code denominated Code Title 24A. 1971 Ga. Laws 709.

Georgia's Juvenile Court Code which applies to chil-

dren under 17 years of age, provides that the juvenile courts of this state "shall have *exclusive* original jurisdiction over juvenile matters and shall be the *sole court* for initiating action: (1) Concerning any child . . ." (emphasis supplied) who, among other things "(d) . . . is alleged to be in need of treatment or commitment as a mentally ill or mentally retarded child. . . ." or is alleged to be unruly or deprived. § 24A-301.

An "unruly child" includes a child who "is habitually disobedient of the reasonable and lawful commands of his parent, guardian or other custodian, and is ungovernable. . . ." § 24A-401(g). A "deprived child" includes a child who "is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, or morals. . . ." *Id.* (h).

Specific jurisdiction is also given "to appoint a guardian of the person or property of any child . . . Provided that such appointment shall be made pursuant to the same requirements of notice and hearing" as in the court of ordinary, § 24A-302, where the interest of the child conflicts with the interest of his parent, guardian or custodian. § 24A-3301.

Children may be taken into custody before or after a court proceeding begins but may not be detained unless detention "is required to protect the person or property of others or of the child. . . ." Proceedings are begun by petition filed by any person, including a law enforcement officer, having personal or informed knowledge, subject to the condition that the court determine and endorse upon the petition that its filing is in the child's and the public's best interest. §§ 24A-1601 and 1602. Summons

issues to the parents, guardian, custodian, guardian ad litem and the child if over 14 years of age. It includes notice of a hearing (within 10 days for a detained child), right to counsel and right to appointed counsel "if unable without undue financial hardship to employ counsel." § 24A-1701.

The public is excluded from knowledge of and access to all hearings. Hearings are conducted by the court without a jury and are recorded. "The court may temporarily exclude the child from the hearing except while allegations of *his* delinquency or unruly conduct are being heard." § 24A-1801.

While the child has a right to counsel, "counsel must be provided for a child not represented by his parent, guardian, or custodian." § 24A-2001.

The court may order the child examined by a physician or psychologist or order urgently needed medical or surgical treatment. § 24A-210.

As to the disposition of mentally ill or mentally retarded children, § 24A-2601 provides:

> "(a) If, at any time, the evidence indicates that a child may be suffering from mental retardation or mental illness, the court may commit this child to an appropriate institution, agency, or individual for study and report on the child's mental condition.
>
> "(b) If it appears from the study and report that the child is committable under the laws of this State as a mentally retarded or mentally ill child, the court shall order the child detained and proceed within 10 days to commit the child to the *Georgia Department*

of Human Resources, Mental Health Division."[41] (emphasis added).

"(c) If the child is found not to be committable, the court shall proceed to the disposition or transfer of the child as otherwise provided by this Code [Title 24A]."

For deprived children the court may fashion an order best suited to protect his "physical, mental and moral welfare", subject to statutory limitations not here relevant, § 24A-2301. Unruly children are disposed of the same as delinquent children. §§ 24A-2302 and 2303.

Juvenile court orders as possibly applicable to this case may not continue in force for more than two years and may be extended by order if a hearing is held after reasonable notice and there is a finding by the court that the extension is necessary. § 24A-2701.

The 1,111 children[42] admitted to Georgia's mental hospitals involuntarily in fiscal years 1969 through 1976 were admitted pursuant to one of these statutory procedures—mental health or juvenile court.

[41] The defendants indicated that with regularity they receive juvenile court orders committing a child to a particular mental hospital instead of to the "Georgia Department of Human Resources, Mental Health Division." They fear that such orders unknowingly limit the department's authority to place the child in another mental hospital in which he can receive more suitable treatment.

[42] See page 10 of this opinion.

THE STATUTE — SCOPE AND USE

A. The Application—

The statutory concept as to the plaintiff class—children under 18 years of age—begins with an application for hospitalization being made "by his parent or guardian." § 88-503.1(a). In practice applications are made by parents and by the 159 county Department of Family and Children Services where such county departments have been designated as custodian of a child by order of a juvenile court.

Psychiatrists, both those now employed by the State and those independent of the parties to this lawsuit, agree that "it's by now a truism in child psychiatry, a truism built over maybe fifty years of clinical experience in a wide variety of settings, that the pathology of children is inextricably related to the pathology of the family. . . ." More often than not the parents as well as the child might need psychiatric help.[43] "A disturbed child in the family can disrupt the family or the child's problems may be brought about, possibly, by the family strife and so forth, so . . . *rarely, if ever*, will you have a purely emotionally disturbed child in a family with no other problems there. So almost without exception, we're talking about family involvement in the child and adolescent program."[44] As further stated by another superintendent, "axiomatic in the treatment of children, is to treat the parents and the child. It's considered to be a constellation of disturbances that exists, that where there is a mentally or emotionally disturbed child, that it relates to the parents." Therefore,

[43] Dr. Eli Charles Messinger's deposition, p. 6.

[44] Dr. Eugene C. Jarrett, III, Superintendent, Southwestern State Hospital at Thomasville, deposition, p. 40.

"the parents and the child are all treated in the treatment plan for the child."[45]

While parents generally make such applications with the best of intentions and with the sincere desire to seek help for their child, the defendants nevertheless recognize what society knows but had rather not admit—"there are a lot of people who still treat [mental hospitals] as dumping grounds."[46]

As to those children for whom application is made by a county Department of Family and Children Services, the defendants now justify this practice by asserting that "the phrase 'parent or guardian' is sufficiently broad to encompass" such county departments "by reason of Ga. Code § 24A-2901" part of the Juvenile Court Act which provides:

> "A custodian to whom legal custody has been given by the court under this Code [Title 24A] has the right to physical custody of the child, the right to determine the nature of the care and treatment of the child, including ordinary medical care and the right and duty to provide for the care, protection, training, and education, and the physical, mental, and moral welfare of the child, subject to the conditions and limitations of the order and to the remaining rights and duties of the child's parents or guardian."

and they say "gives the custodian the legal right to hospitalize the child. . . ."[47] The defendants do not explain how the words "ordinary medical care" include long-term

[45] Dr. Lawson H. Bowling, Superintendent, Georgia Regional Hospital at Atlanta, deposition, p. 20.
[46] Dr. John P. Filley, Director, Child and Adolescent Mental Health Services, deposition, p. 48.
[47] February 11, 1976, letter of Assistant Attorney General R. Douglas Lackey.

detention of a child in a mental hospital or why the inclusion in the Juvenile Court Act of a specific provision for the disposition by the juvenile court of mentally ill children, § 24A-2601, does not indirectly but explicitly say that the juvenile court and not a custodian, is to determine whether or not mentally ill children are to be hospitalized.

B. Admission for Observation and Diagnosis and for Treatment.

Next, the statutory concept is for such an application to be presented to the superintendent of a regional hospital, who is authorized to receive a child "for observation and diagnosis." § 88.503.1(a). In practice children are received by being confined or placed in a regional mental hospital behind locked doors along with other children who are already there for care and treatment or for observation and diagnosis. Since application for discharge may be requested only after five days, receipt for observation and diagnosis means that the child is detained for a minimum of five days. § 88.503.3. There is no statutory maximum period.

The observation and diagnosis study is conducted under the supervision of a psychiatrist by psychologists and social workers. While no period of time is prescribed by statute or regulation, the general time consumed for such study seems to be about a week.

Then the statutory concept is that "if found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment . . . and . . . may be detained by such facility for such period and under such conditions as may be authorized by law." § 88-

503.1(a). In practice the language "evidence of mental illness and to be suitable for treatment" is as indefinite and elusive to the psychiatrists employed by the state as it is to a layman. Note the following portion of the deposition of Dr. John P. Filley, Director, Child and Mental Health Services:

> "Q. I realize this is a very broad question, but when you say, 'Hospitalization is the appropriate treatment,' could you be somewhat more specific about the kinds of situations in which hospitalization becomes appropriate, what the family situation might be, why hospitalization is preferrable at that time in the child's life.
>
> "A. It can be quite a variety of circumstances that can make it appropriate for a child to be hospitalized. One would be a very acute, severe degree of disturbance. The child's behavior is quite out of control, and he needs to be in a contained environment until some stabilization is achieved through medication, through program and therapy and so on that brings about a greater degree of capability on the child's part to function within normal controls.
>
> "Other situations, due to social circumstances the child's interaction with his parents may be in sort of a vicious circle pattern where it's getting worse and worse; and the parents are not able to change or interrupt this vicious circle; and a disturbance builds. It may be appropriate to hospitalize the child as part of breaking that cycle and achieving a more stable relationship.
>
> "The broad general statement would be that these

> would be the two major conditions in which we say hospitalization is appropriate."

Id. at 9. In sum and substance Dr. Filley testified that the decision to hospitalize for care and treatment comes about in the following manner: The parent may come in saying, 'I can't handle it any more; do something.' And, they say at the hospital or it might be the psychiatrist who says, "I think hospitalization is indicated.' The parent would agree and that would decide it." *Id.* at 53.

The hospitalization of children for whom a county Department of Family and Children Services is custodian generally results from a determination that foster parental care is unavailable or has been tried and found to be unworkable, leaving hospitalization as the only available alternative. As already pointed out, Georgia has not yet provided other less restrictive forms of treatment. Ms. Hester Dixon, Social Services Consultant for the Department of Human Resources, has overall responsibility for foster care. She testified that most foster parents expect to provide short term care (deposition at 30), and that the State has trouble placing the following children in foster homes:

> "Q. Okay. Are some children in your experience, to the best of your knowledge, more difficult to place, let's say, than other children?
>
> "A. Yes.
>
> "Q. Is there a great difference, let's say, between—how would—can you give us some examples of that, things that come to mind for you, like of a child that might be difficult to place?
>
> "A. Well, generally a child twelve, thirteen years

> and older is more difficult to place, regardless. The age itself has a great deal to do with the problems of placement. A child—children who are bed-wetters are difficult to place—more difficult to place. Children who have come into contact with the courts are more difficult to place. Children who have—who have been diagnosed as having some kind of emotional problems are more difficult to place. Children with physical handicaps."

Deposition of Ms. Hester Dixon at 28.

J. R.'s history vividly illustrates what she is describing. Note also the testimony of the director of the county Department of Family and Children Services that participated in the decision to hospitalize J. R.: "The younger the child, the easier it is to find a [foster home] place. And, pre-school, very definitely, easy. For school age children it's hard to find homes for and teenagers, it's just about nil."[48]

C. Discharge by Superintendent of Voluntary Patients.

While the statute says that "the superintendent . . . shall discharge any voluntary patient who has recovered from his mental illness or who has sufficiently improved that the superintendent determines that hospitalization of the patient is no longer desirable. . . ." § 88-503.2, in practice in the absence of ready, willing, and able parents the superintendent is without means to effect this statutory command.

The information freely furnished to the court and here-

[48] Deposition of Mrs. Gladelle Whitaker at 55.

tofore summarized and the testimony of state employed psychiatrists consistently shows that "there are presently children hospitalized . . . who hospital personnel . . . indicate do not need to be institutionalized." The defendants do not regularly keep a list of such children because they "have no capability of affecting the situation." This unnecessary hospitalization continues in spite of the generally acknowledged fact that it is harmful for such children to continue to be unnecessarily hospitalized.[49]

The absence of parents ready, willing and able to again accept their child, is unfortunately a normal situation. As Dr. James B. Craig, now Superintendent of the Georgia Regional Hospital at Savannah and formerly Superintendent of Milledgeville State Hospital now called Central State Hospital, testified: "Yes, you always have a few of these [parents who are reluctant to take their children out of the hospital after the staff recommends discharge] because with the kinds of, say, cases you get admitted to a hospital, meaning that many times it's because of their disinterest and inability to get along that the child gets sick." (Deposition at 11).

Without available parents, the regional hospitals are dependent upon the Department of Family and Children Services to find a suitable placement. As already discussed, the only available placements are foster care and a limited number of specialized foster care which means that generally for emotionally disturbed children who have been hospitalized there is no available, suitable placement. If D.F.C.S." is unable to take the child, he stays in the mental hospital.[50]

[49] Dr. John P. Filley, deposition at 60 and 73A.
[50] Dr. John P. Filley, deposition at 73B.

D. Discharge on Application.

According to the statute "a voluntary patient who is admitted . . . pursuant to section 88-503.1, or his legal guardian, parent, spouse, attorney, or adult next-of-kin, may request his discharge in writing. . . . If the patient was admitted before the age of 18 on the application of his parent or guardian under section 88.503.1, his discharge prior to becoming 18 years of age may be conditioned upon the consent thereto of his parent or guardian. . . ." § 88-503.3. In practice the State takes this to mean that in the case of a voluntarily admitted child, his discharge can be requested only by his parent or guardian.[51] Children thus in practice have a right to leave only when the hospital and their parent or guardian agree.[52]

E. Availability of Other Statutory Procedures.

§ 88-503.3(b) provides that "proceedings for the involuntary hospitalization of . . . a voluntary patient shall not be commenced unless the discharge of the voluntary patient is first requested as provided in subsection (a) hereof." In practice this means that a parent or guardian by not requesting the discharge of his child can effectively prohibit the child being considered for involuntary hospitalization pursuant to the heretofore discussed laws providing generally for the hospitalization of the mentally ill through the court of ordinary or in the juvenile courts of this state.

F. Procedural Safeguards.

Neither the statutory scheme nor the practices and

[51] Dr. Lawson H. Bowling, Superintendent, Georgia Regional Hospital at Atlanta, deposition at 32.

[52] Dr. John P. Filley, deposition at 109.

policies utilized by the defendants provide for any procedural safeguards. As the plaintiffs urge, children are institutionalized without a hearing or other procedural safeguards; are hospitalized without initial or periodic consideration of placement in the least drastic environment necessary for treatment; and are not afforded a hearing at any time for the determination of an appropriate required time for discharge.

In concept and practice the statute vests in parents and guardians, including the defendants as custodians, and in superintendents of state mental hospitals an unbridled discretion to admit and detain emotionally disturbed children in Georgia's mental hospitals at least until their 18th birthday.

LIBERTY AND DUE PROCESS

Like *O'Connor* v. *Donaldson,* 422 U.S. 563, 45 L.Ed 2d 396, 95 S.Ct. 2486 (1975), and the question[53] therein posed and answered, this case raises the most important question of every child's constitutional right to liberty, not only the liberty that includes freedom from bodily restraint, *Meyer* v. *Nebraska,* 262 U.S. 390, 67 L.Ed 1042, 1045, 43 S.Ct. 625 (1922), but also the liberty that includes the freedom of an ordinary, every-day child in these United States of America—the freedom to live with mothers, fathers, brothers and sisters in whatever the family abode may be; the freedom to be loved and to be spanked; the freedom to go in and out the door, to run and play, to laugh and cry, to fight and fuss, to stand up and fall down, to play childish games; the freedom to

[53] The court therein stated, "As we view it, this case raises a single, relatively simple, but nonetheless important question concerning *every man's constitutional right to liberty.*" Id. at 405. (emphasis added.)

go to school and to frolic with school mates; the freedom to go to Sunday school and church; the freedom to watch and listen or not to watch and listen to television; the freedom to buy candy at the corner store; the freedom to be a normal child in a normal household cared for by normal parents.

To unnecessarily confine and detain a child in a mental hospital and thereby cause him to possibly suffer severe emotional and psychic harm, *Matthews* v. *Hardy*, 420 F. 2d 607, 611 (D. C. Cir. 1969), to demean himself, and to magnify social ostracism, *In re Ballay*, 482 F.2d 648, 667-69 (D.C. Cir. 1973), is to deprive him of a child's freedom just as much if not more so than a child is deprived of his freedom by being civilly committed as a juvenile delinquent. *In re Gault*, 387 U.S. 1, 18 L.Ed 2d 527, 87 S.Ct. 1428 (1967). To paraphrase what the Court there said: Ultimately, however, we confront the reality of that portion of the mental health process with which we deal in this case. A child is alleged to be emotionally disturbed. The child is admitted to a mental hospital where he may be detained and restrained of liberty for years. It is of no constitutional consequence—and of limited practical meaning—that the institution to which he is admitted and in which he is detained is called a hospital. The fact of the matter is that however euphemistic the title, a regional hospital named Central State Hospital or Georgia Mental Health Institution is an institution known by all as one for the confinement of mentally ill children and adults, in which the child is confined for a greater or lesser time. His world becomes a building with locked doors and windows, regimented routine and institutional hours. Instead of mother and father and sisters and brothers and friends and classmates, his

world is peopled by psychiatrists, psychologists, social workers, state employees and children who are to a greater or lesser extent, also emotionally disturbed.

"In view of this, it would be extraordinary if our constitution did not require the procedural regularity and the exercise of care implied in the phrase 'due process' ", *In re Gault, supra,* at 27, 546, for children to be confined and detained under Georgia's voluntary admissions statute.

While the care that is implied in—the procedural regularity that is called for by the phrase "due process", is flexible and such as the partciular situation demands, *Morrissey* v. *Brewer*, 408 U.S. 471, 33 L.Ed 2d 484, 92 S.Ct. 2593 (1972), it traditionally includes at least the right after notice to be heard before an impartial tribunal. *Powell* v. *Alabama*, 287 U.S. 45, 77 L.Ed 2d 158, 53 S.Ct. 55 (1932). As Daniel Webster's well-chosen words suggest, it "mean[s] a law which hears before it condemns, which proceeds on inquiry and renders judgment only after trial." (citation omitted). Black's Law Dictionary, Revised 4th Ed. at 590; partially quoted *Powell* v. *Alabama, supra*, at 68, 170.

The defendants' contention that through this statute the state as *parens patriae* merely assists parents in the performance of their traditional parental duty of providing for the "maintenance, protection and education of their children," 1933 Ga. Code Ann. § 74-105, and is nothing more than a statutory confirmation of the liberty that parents and guardians have to direct the upbringing of children under their control, *Pierce* v. *Society of Sisters*, 268 U.S. 510, 69 L.Ed 1070, 45 S.Ct. 571 (1924), *Wisconsin* v. *Yoder*, 406 U.S. 205, 32 L.Ed 2d 15, 92

S.Ct. 1526 (1972) suggests that this statute gives to parents only the authority that they genuinely need to hospitalize their children and thus supplies the due process[54] that their situation demands. This contention overlooks the age-old principle that "the touchstone of due process is protection of the individual against arbitrary action of government, Dent v. West Virginia, 129 U.S. 114, 123, 32 L.Ed 2d 623, 9 S.Ct. 231 (1899)," *Wolff* v. *McDonnell*, 418 U.S. 539, 558, 41 L.Ed 2d 935, 952, 94 S.Ct. 2963 (1974). Most parents accept and faithfully perform their parental duties and given this unlimited statutory authority to admit their children to a mental hospital, would use that authority only when it is genuinely necessary to do so. Unfortunately, as the evidence indicates, there are some parents who abuse that authority and who under the guise of admitting a child to a mental hospital actually abandon their child to the state. As Dr. Filley suggested in his deposition, some still look upon mental hospitals as a "dumping ground". See text accompanying note 46, *supra*.

By this statute the state gives to parents the power to arbitrarily admit their children to a mental hospital for an indefinite period of time. Where "the state undertakes to act in parens patriae, it has the inescapable duty to

[54] It is also argued that parents and guardians can waive their child's constitutional rights, *In re Gault*, 387 U.S. 1, 18 L.Ed 2d 527, 87 S.Ct. 1428 (1967), but for constitutional rights to be waived, they must first be statutorily recognized. Georgia's statute does not accord but instead abolishes all of a child's due process rights and says loud and clear that a child has no right to contest the decision of the parent and the superintendent to hospitalize him. Secondly, even if the statute provided for waiver, appropriate due process protections herein absent would have to be provided as a condition to a valid parental waiver of a child's Fourteenth Amendment due process rights, *Kent* v. *United States*, 383 U.S. 541, 16 L.Ed 2d 84, 86 S.Ct. 1045 (1966).

vouchsafe due process. . . ." *Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968), and this necessarily includes procedural safeguards to see that even parents do not use the power to indefinitely hospitalize children in an arbitrary manner.

The defendants further assert that nevertheless children are constitutionally protected by the independent judgment exercised by superintendents of Georgia's mental hospitals and their staff psychiatrists, psychologists and social workers. They say that the physician's license issued by competent authority is assurance that the physician possesses the requisite qualifications and will use them only in a child patient's best interest. *Doe* v. *Bolton*, 410 U.S. 179, 35 L.Ed 2d 201, 93 S.Ct. 739 (1973). Defendants assert that plaintiffs by suggesting to the contrary are indicting the entire psychiatric branch of the medical profession.

The court is impressed by the conscientious, dedicated state employed psychiatrists who with the help of equally conscientious, dedicated state employed psychologists and social workers, faithfully care for the plaintiff children to the extent that state furnished resources and facilities permit. Nevertheless, psychiatry according to psychiatrists is still an inexact science as to which there is the opportunity for wide, sincere differences of opinion among psychiatrists. The opportunity for such wide differences of opinion stems initially and primarily from the fact that psychiatry is dependent upon information that comes from the patient and from other people—parents, family, friends, and staff—who themselves have their own personal interests and problems in communication.[55] To sug-

[55] Dr. Eli Charles Messinger, deposition at 17.

gest, as we here do, that psychiatrists are not infallible is not an indictment of psychiatry. It is simply to say that psychiatrists like all humans are capable of erring. Since they are capable of erring, psychiatrists like parents cannot statutorily be given the power to confine a child in a mental hospital without procedural safeguards being imposed to guard against errors in judgment and/or the arbitrariness that the best of us humans exhibit from time to time.

That state officialdom—knowing definitely since said November 1973 study commission report of the crying need for non-hospital, alternative resources for the care and treatment of plaintiff children, and further knowing from said report of the large number of children who would not need hospitalization if other forms of care were available—has failed to even endeavor to provide such alternative resources demonstrates that even well-meaning state officials cannot be given the unlimited statutory authority to determine under what circumstances and for how long plaintiff children will be confined and detained by the state in its mental hospitals. Their continued assertions in the face of this lawsuit that it is their opinion that Georgia's regional hospitals are offering these children appropriate treatment (Affidavit of Dr. Skelton following January 15, 1976, meeting with the Governor and Chairmen of the Senate and House Appropriations Committees), is small comfort to the 46 children who according to the defendants and their report of January 24, 1976, could now be treated and cared for in non-hospital surroundings if such were only available.

As was so appropriately said in *Covington* v. *Harris*, 419 F.2d 617 (D.C. Cir. 1969):

> "Not only the principle of judicial review, but the whole scheme of American government, reflects an institutionalized mistrust of any such unchecked and unbalanced power over essential liberties. That mistrust does not depend on an assumption of inveterate venality or incompetence on the part of men in power, be they President, legislators, administrators, judges, or doctors. It is not doctors' nature, but human nature, which benefits from the prospect and the fact of supervision. Indeed, the limited scope of judicial review of hospital decisions necessarily assumes the good faith and professional expertise of the hospital staff. Judicial review is only a safety catch against the fallibility of the best of men; and not the least of its services is to spur them to doublecheck their own performance and provide them with a checklist by which they may readily do so." *Id.* at 621-22.

It is thus apparent that this statute supplies not the flexible due process that the situation of the plaintiff children demands but instead, absolutely no due process. It is also apparent that it affords to parents, guardians, the Department of Human Resources as Custodian, and superintendents the "unchecked and unbalanced power over [the] essential liberties . . ." of these children that is universally mistrusted by our "whole scheme of American government." The doublecheck that is needed is that which is guaranteed by the Fourteenth Amendment—due process of law. There being none the statute in question violates the Due Process Clause of the Fourteenth Amendment and is unconstitutional.

THE REMEDY

While no evidentiary hearing has been held, the information now furnished to the court indicates that the

defendants as psychiatrists are of the belief that approximately 46 plaintiff children could be cared for in a less drastic, non-hospital environment if such an environment were available. The choices are many—

a. small group crisis home;
b. small group home;
c. specialized small group living home;
d. small group home clustering;
e. therapeutic camp life;
f. specialized foster parent program;
g. rotating parent program;
h. home care services, and *last but not least*
i. private child care agencies.

It is not for this court of three lay judges to choose the appropriate, less drastic form of care for each of these children; that decision we leave to the professional judgment of the defendant psychiatrists. It is, however, for this court to order[56] the defendants to proceed as expeditiously as is reasonably possible (1) to provide necessary physical resources and personnel for whatever non-hospital facilities are deemed by them to be most appropriate for these children, and (2) to place these children in such non-hospital facilities as soon as reasonably appropriate. *The defendants shall further spend such money of the State of Georgia as is reasonably necessary to provide such non-hospital facilities and personnel and to place these children in such non-hospital facilities. Ex parte Young,* 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed 714 (1908);

[56] See *In re Gault,* 387 U.S. 1, 27, 18 L.Ed 2d 527, 546, 87 S.Ct. 1428 (1967), and *Jackson v. Indiana,* 406 U.S. 715, 738, 32 L.Ed 2d 435, 451, 92 S.Ct. 1845 (1972): "at the least, due process requires that the *nature and duration* of commitment bear some reasonable relation to the purpose for which the individual is committed." (emphasis added.)

Goldberg v. *Kelly,* 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed 287 (1970); *Griffin* v. *County School Board of Prince Edward,* 377 U.S. 218, 12 L.Ed 2d 256, 84 S.Ct. 1226 (1964); *Wyatt* v. *Aderholt,* 503 F.2d 1305 (5th Cir. 1974).

The defendants as to every child under 18 years of age in their custody pursuant to this statute on the date of this order must within sixty (60) days:

(a) commence proceedings under Georgia's Juvenile Court Act or other mental health laws not herein found unconstitutional, or

(b) make necessary arrangements to completely remove the child from the custody of the defendants or any other official or agency of the State of Georgia.

The commencement of such proceedings will not terminate or deprive this court of further jurisdiction of every child who is a member of the plaintiff class. Jurisdiction is expressly retained for the following purposes:

(a) Receiving from the defendants semi-annual written reports to be filed within 30 days after each June 30 and December 31, under seal with the clerk of this court. Each such report shall contain a complete account of the defendants' compliance with this and all further orders, including complete copies of all legal and medical papers pertaining to every child under 18 years of age who within the reporting period is or has been in defendants' custody for hospital or non-hospital mental health voluntary care and treatment.

(b) Such further proceedings, hearings and orders as may be necessary to effect this remedial order.

Subject to the aforesaid the defendants, their agents, servants, employees, and attorneys and all persons in active concert or participation with them who receive actual notice of this order by personal service or otherwise, are hereby permanently enjoined and restrained from directly as the result of the request of a parent or guardian, or indirectly through the Department of Human Resources or any division or official thereof being appointed custodian, further detaining or confining any child under 18 years of age in any mental health facility in this state pursuant to the voluntary admissions by parent or guardian statute herein declared to be unconstitutional, to wit:

> "§ 88-503.1 (a) The superintendent of any facility may receive for observation and diagnosis . . . any individual under 18 years of age for whom such application is made by his parent or guardian."

The plaintiff class having been allowed to proceed in forma pauperis, no security or bond is required for the issuance of the injunction. Rule 65(c), Federal Rules of Civil Procedure.

The issue necessitating the convening of this district court of three judges having been finally decided, this district court of three judges is hereby dissolved.

The parties are directed to appear at the United States Courthouse, Macon, Georgia, at 9:30 a.m. on the *21st* day of April, 1976, before the Honorable Wilbur D. Owens, Jr., United States District Judge, and to then report in full to the court on all efforts made to effect this order. At that time such further orders as are needed to clarify or make explicit the remedial order of this court, will be passed.

SO ORDERED, this the 26th day of February, 1976.

/s/ GRIFFIN B. BELL

GRIFFIN B. BELL
United States Circuit Judge

/s/ W. A. BOOTLE

W. A. BOOTLE
Senior United States District Judge

/s/ WILBUR D. OWENS, JR.

WILBUR D. OWENS, JR.
United States District Judge

APPENDIX B

[Filed in Clerk's Office March 11, 1976.
Walter F. Doyle, Clerk]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

J. L. and J. R., minors, individually and as representatives of a class consisting of all persons younger than 18 years of age, now or hereafter received by any defendant for observation or diagnosis and/or detained for care or treatment at any facility within the State of Georgia, pursuant to 1969 Georgia Laws pp. 505-517, informally codified as Georgia Code Annotated § 88-503.1,

Plaintiffs,

- v -

JAMES PARHAM, individually and as Commissioner of the Department of Human Resources, DOUGLAS SKELTON, individually and as Director of the Division of Mental Health and W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital,

Defendants.

CIVIL ACTION
NO. 75-163-MAC

JUDGMENT PURSUANT TO RULE 54(b), FEDERAL RULES OF CIVIL PROCEDURE

A district court of three judges having rendered its decision on February 26, 1976, as to all matters required to be decided and heard by a court of three judges and having dissolved itself, this constitutes an express determination by the court that there is no just reason for delay of entry of judgment as to all matters required to be heard by a district court of three judges and an express direction for the entry of said judgment. Rule 54(b), Federal Rules of Civil Procedure.

In the manner set forth in the remedial portion of said February 26, 1976, decision which begins on page 42 and continues through page 45, judgment is therefore rendered for the plaintiffs individually and as representatives of the plaintiff class and against the defendants: JAMES PARHAM, individually and as Commissioner of the Department of Human Resources, DOUGLAS SKELTON, individually and as Director of the Division of Mental Health, and W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital.

Judgment pursuant to Rule 54, Federal Rules of Civil Procedure, is expressly not entered as to those portions of said February 26, 1976, order (a) by which a single district judge court continues to have jurisdiction of every child who is a member of the plaintiff class for the purposes stated on pages 43 and 44, and (b) directing the parties to appear on April 21, 1976, before a single district judge to then report in full on all efforts made to effect this order at which time further orders needed to clarify or make explicit said remedial order may be passed by a single district judge.

This 11th day of March, 1976.

/s/ WALTER F. DOYLE

WALTER F. DOYLE, Clerk
United States District Court

Entry directed by and
form approved by

/s/ WILBUR D. OWENS, JR.

WILBUR D. OWENS, JR.
United States District Judge

APPENDIX C

[Filed in Clerk's Office March 24, 1976.
Walter F. Doyle, Clerk. By: M.M.B., Deputy Clerk.]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA

MACON DIVISION

J. L. and J. R., Minors, Individually and on behalf of all others similarly situated, *Plaintiffs,* - v - JAMES PARHAM, Individually and as Commissioner of the Department of Human Resources, DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health; W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital, *Defendants.*	CIVIL NO. 75-163-MAC

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that T. M. "Jim" Parham, Douglas Skelton, M.D. and W. T. Smith, defendants above named, individually and in their official capacities, hereby appeal to the Supreme Court of the United States, from the order of this Court entered in this action on the 26th day of

February, 1976, and the final judgment entered thereon on the 11th day of March, 1976.

This appeal is taken pursuant to 28 U.S.C. §1253.

This 24th day of March ,1976.

ARTHUR K. BOLTON
ATTORNEY GENERAL

ROBERT S. STUBBS, II
CHIEF DEPUTY ATTORNEY GENERAL

/s/ DON A. LANGHAM
DON A. LANGHAM
DEPUTY ATTORNEY GENERAL

/s/ TIMOTHY J. SWEENEY
TIMOTHY J. SWEENEY
SENIOR ASSISTANT ATTORNEY GENERAL

/s/ R. DOUGLAS LACKEY
R. DOUGLAS LACKEY
ASSISTANT ATTORNEY GENERAL

Please Serve:

Timothy J. Sweeney
132 State Judicial Building
Atlanta, Georgia 30334
Phone: 656-3340

CERTIFICATE OF SERVICE

I, Timothy J. Sweeney, one of the attorneys for defendants herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served each party in this action with three copies of the foregoing Notice of Appeal, by depositing three copies of the same in the United States mail, with first class postage prepaid, addressed as follows:

David Goren
Georgia Legal Services Program
653 Second Street
Macon, Georgia 31201

This 24th day of March, 1976.

/s/ TIMOTHY J. SWEENEY
TIMOTHY J. SWEENEY
Senior Assistant Attorney General

APPENDIX D

STATUTES

88-503.1. **Authority to receive voluntary patients.**— (a) The superintendent of any facility may receive for observation and diagnosis any individual 18 years of age, or older, making application therefor, any individual under 18 years of age for whom such application is made by his parent or guardian and any person legally adjudged to be incompetent for whom such application is made by his guardian. If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.

(b) The superintendent of any evaluating facility may receive for observation and diagnosis any individual 14 years of age or older who makes application therefor. If such individual is under 18 years of age, his parent or guardian may apply for his discharge and the superintendent shall release the patient within five days of such application for discharge.

(Acts 1969, pp. 505, 517.)

Supreme Court, U. S.
FILED
AUG 15 1977
MICHAEL RODAK, JR., CLERK

VOLUME I—Pages 1-351
APPENDIX

IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

APPEAL DOCKETED MAY 21, 1976
JURISDICTION NOTED MAY 31, 1977

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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

J. L. and J. R., Minors, Individually and on behalf of all others similarly situated,

Plaintiffs,

v.

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources; W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health; W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Defendants.

RELEVANT DOCKET ENTRIES

1975

October 24, Complaint filed.

October 24, Motion for Preliminary Injunction, for Class Action and for the Convening of a Three-Judge Court filed.

October 24, ORDER, setting hearing for Thursday, October 30, 1975 at 5:00 P.M., in Macon, Georgia.

October 30, Hearing held before Judge Wilbur D. Owens, pursuant to the order issued October 24.

November 7, ORDER of Chief Judge John R. Brown, constituting Three-Judge Court, filed.

November 17, ORDER governing production of certain confidential documents of Central Georgia Regional Hospital, the Baldwin County Department of Family and Children Services, the Stephens County Department of Family and Children and the Department of Human Resources, filed.

November 18, ORDER confirming that the action was to be maintained as a class action filed.

November 19, Defenses and answer for all Defendants filed.

November 19, Affidavit of Janet Scott filed.

November 19, Revised Statement of Facts filed.

November 19, Stipulation of Facts for the district court hearing filed.

November 19, Hearing held by the district court.

November 21, Plaintiffs' Motion for Entry and Inspection filed.

November 21, ORDER of the district court granting Plaintiffs' Motion for Entry and Inspection filed.

December 2, Deposition of Eli Charles Messinger filed.

December 12, Depositions of Anne Etheridge and Nancy Autry filed.

December 12, Deposition of Dr. W. Douglas Skelton filed.

December 12, Deposition of Dr. James B. Craig filed.

December 15, Deposition of Arthur Falek filed.

December 19, Deposition of Daniel Offer filed.

December 19, Deposition of Dr. John Paton Filley filed.

December 19, Deposition of Walter Gove filed.

December 19, Deposition of Gladelle Whitaker filed.

December 19, Deposition of Martha Ann Taylor filed.

December 19, Deposition of Vivian Schoonmaker filed.

December 19, ORDER of the district court directing that all persons examining the record in this matter not disclose the names of the children involved except by Order of the Court, filed.

December 22, Received Supplemental Brief on Behalf of the Defendants together with Appendixes A, B, and C to Defendants' Supplemental Brief.

December 22, Stipulated Submission of Exhibits to Depositions filed.

December 22, Post-Discovery Memorandum of Plaintiffs received.

December 23, Deposition of Dr. Eugene C. Jarrett, III filed.

December 23, Deposition of Dr. Luciano L'Abate filed.

December 23, Deposition of Wladyslaw P. Mazur filed.

December 23, Deposition of Dr. Loren R. Mosher filed.

December 23, Depositions of Dr. Donald G. Miles and Dr. William Wieland filed.

December 23, Deposition of Hester Dixon filed.

December 23, Deposition of Dr. Everett C. Kuglar filed.

December 23, Depositions of Dr. John J. Gates and Dr. W. T. Smith filed.

December 23, Deposition of Dr. Lawson H. Bowling filed.

February 26, Filed Opinion and Order of the district court granting permanent injunction, ruling unconstitutional Georgia Law permitting parents to place children in mental institutions without a hearing and ordering State officials to provide non-hospital facilities for children under 18 years of age.

March 8, ORDER of Chief Judge John R. Brown reconstituting the Three-Judge District Court filed.

March 10, Defendants' Motion to Stay filed.

March 10, Affidavits of Romae T. Powell, W. Douglas Skelton and Dennis F. Jones in Support of Defendants' Motion to Stay filed.

March 11, Hearing held by district court on Defendants' Motion to Stay.

March 11, Judgment pursuant to Rule 54(b) entered.

March 17, ORDER of district court denying Defendants' Motion to Stay Pending Appeal filed.

March 24, Defendants' Notice of Appeal to the Fifth Circuit Court of Appeals from the Order of the district court filed.

March 24, Defendants' Notice of Appeal to the Supreme Court of the United States from the Order of the district court filed.

March 24, Certified Copy of the Notice of Appeal to the Supreme Court of the United States and to the Fifth Circuit Court of Appeals, together with certified copy of Docket Sheets forwarded to the Supreme Court of the United States.

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

[1] [Filed at 10:50 A.M., Oct. 24, 1975,
Dorothy F. Motes, Deputy Clerk, U.S. District Court,
Middle District of Georgia]

J. L. and J.R., minors individually and on behalf of all others similarly situated,

Plaintiffs,

vs.

JAMES PARHAM, individually and as Commissioner of the Department of Human Resources;
DOUGLAS SKELTON, individually and as Director of the Division of Mental Health;
W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital,

Defendants.

CIVIL ACTION NO. 75-163-MAC

COMPLAINT

Three-Judge Court
(Civil Rights Class Action)

I.

PRELIMINARY STATEMENT

1.

Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief, and damges, for violations of their civil rights resulting from the operation of Georgia Code §88-503.1(a). This statutory scheme permits parents and guardians of per-

sons younger than 18 years of age to cause the involuntary commitment of those persons to state mental health facilities under the guise of a "voluntary" admission statute. The statutory scheme conflicts with the due process clause of the Fourteenth Amendment to the United States Constitution in that it allows for the involuntary commitment of persons younger than 18 years of age: (1) without a hearing and other procedural safeguards and (2) without initial and periodic consideration of placement in the least drastic environment necessary for treatment. This cause of action, [2] arises under 42 U.S.C. §1983. Since these statutes are of state-wide application, a three-judge court is required.

II.

JURISDICTION

2.

Jurisdiction is conferred upon this Court by:

a. 28 U.S.C. §1343(3), relating to original jurisdiction under 42 U.S.C. §1983.

b. 28 U.S.C. §2201, §2202, relating to declaratory relief.

c. 28 U.S.C. §2281, §2284, relating to injunctive relief and three-judge courts.

III.

THREE-JUDGE COURT

3.

This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§2281 and 2284 since plaintiffs seek an injunction to restrain defendant state officers

from the enforcement, execution and operation of a state statute [Georgia Code §88-503.1(a)] of state-wide applicability on the ground that the statutory scheme is contrary to the United States Constitution.

IV.

PLAINTIFFS

4.

Plaintiff J. L. is a citizen of Georgia, age 12, who is being held against his will by the defendants or under their direction having been committed by his adoptive mother and stepfather pursuant to the challenged statute, Georgia Code §88-503.1(a).

5.

Plaintiff J. L. was committed without notice, hearing, right to counsel or order of a court.

[3] 6.

Plaintiff J. R. is a citizen of Georgia, age 12, who is being held against his will by the defendants or under their direction having been committed by the Stephens County Department of Family and Children Services pursuant to the challenged statute, Georgia Code §88-503.1(a).

7.

Plaintiff J. R. was committed without notice, hearing, right to counsel or order of a court.

V.

DEFENDANTS

8.

Defendant JAMES PARHAM is the Commissioner of the Department of Human Resources for the State of

Georgia. Pursuant to Acts 1972, pp. 1015, 1046 (Ga. Code §40-35101), defendant Parham has the responsibility to execute and administer all functions of the Department of Human Resources including the Division of Mental Health.

9.

Defendant DOUGLAS SKELTON is the Director of the Division of Mental Health and has direct administrative responsibility for controlling all mental hospitals under the Division of Mental Health.

10.

Defendant W. T. SMITH is the Chief Medical Officer of Central State Hospital and has direct administrative responsibility for the admission of persons to Central State Hospital.

VI.

CLASS ACTION

11.

The named plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

[4] 12.

The members of the class of plaintiffs similarly situated are all persons younger than eighteen years of age who have been, are, or may be committed by their parents or legal guardians to a state mental health facility under the direction and control of defendants Parham and Skelton pursuant to Georgia Code §88-503.1(a).

13.

The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical

(and the knowledge of the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

VII.

FACTUAL ALLEGATIONS

— PLAINTIFF J. L.

14.

Plaintiff J. L. was committed to Central State Hospital on May 18, 1970, pursuant to Georgia Code §88-503.1(a). He was 7 years of age at the time of his commitment, and of normal intelligence.

15.

He was committed by his adoptive mother and stepfather, although he did not wish to enter the hospital then and does not wish to stay there now.

[5] 16.

At the time of his commitment, J. L. was not mentally ill and did not present an imminent likelihood of serious harm to himself or others.

17.

At the time of his commitment, J. L. was not afforded meaningful notice, a hearing, and other procedural safeguards to determine whether (1) he was mentally ill and presented an imminent likelihood of serious harm to him-

self or others, and (2) if hospitalization was the least drastic environment necessary for his treatment.

18.

J. L. was confined in Central State Hospital from May 18, 1970, through September 18, 1972, when he was released on furlough. Due to existing family tension, neither his adoptive mother nor his stepfather were able to meet J. L.'s needs and he was forced to return to the institution within ten days. He has been continuously confined since that date.

19.

In April, 1974, J. L.'s adoptive parents voluntarily relinquished their parental rights to Central State Hospital. J. L. has not seen his adoptive parents since that time.

20.

As a result of his inappropriate and unconstitutional institutionalization, J. L. has been and is being subjected to a regimented and standardized institutional routine which stifles his individual development and his opportunity to assume personal responsibility. He is forced to live with patients whose sometimes bizarre and frightening behaviors cannot be avoided. He has been subjected to a program of chemotherapy which has had and will continue to have long term detrimental physical and psychological effects on his development. His IQ has consistently [6] declined. He has developed allergies and respiratory problems and manifests deep feelings of insecurity, inadequacy, and hopelessness. He is stigmatized by the label of "mental patient" which has had profound reprecussions on his self-image and self-confidence and which will continue to influence, overtly or subtlely, the manner in which he will be treated the rest of his life.

21.

In the opinion of experienced and competent psychiatric personnel, J. L. is suffering from institutionalization and needs immediate placement in a less drastic environment.

22.

J. L. has not been afforded periodic consideration for placement in the least drastic environment.

23.

J. L. has not been placed in the least drastic environment.

24.

Although the defendants have known or should have known of J. L.'s inappropriate placement, J. L. remains incarcerated against his will at Central State Hospital.

PLAINTIFF J. R.

25.

Plaintiff J. R. was committed to Central State Hospital on June 24, 1970, pursuant to Georgia Code §88-503.1(a). He was 7 years of age at that time and was of average or slightly below average intelligence.

26.

After six placements in foster homes which, in each case, J. R. lost his place to a more favored child, he was committed by his legal guardian, the Stephens County Department of Family and Children Services (DFCS). DFCS had assumed custody on October 27, 1966, after the Juvenile Court of Stephens County had declared him to be a neglected child and removed him from his natural parents. J. R. has had no contact with either of his natural parents since his first foster placement.

[7]

27.

At the time of his commitment, J. R. did not wish to enter the hospital and does not wish to stay there now.

28.

At the time of his commitment, J. R. was not mentally ill and did not present an imminent likelihood of serious harm to himself or others.

29.

At the time of his commitment, J. R. was not afforded meaningful notice, a hearing, and other procedural safeguards to determine (1) whether he was mentally ill and presented an imminent likelihood of serious harm to himself or others, and (2) if hospitalization was the least drastic environment necessary for his treatment.

30.

In 1973, experienced and competent psychiatric personnel concluded that J. R. no longer needed to be confined at Central State Hospital and recommended that he be placed in a less drastic environment.

31.

J. R. has been continuously confined to Central State Hospital from June 24, 1970, through the date of the filing of this Complaint.

32.

J. R. is now 12 years old. He has had no contact outside the hospital for the last five years except for two to four temporary holiday visits to foster homes.

33.

As a result of his inappropriate and unconstitutional institutionalization, J. R. has been and is being subjected

[8]

to a regimented and standardized institutional routine which stifles his individual development and his opportunity to assume personal [8] responsibility. He is forced to live with patients whose sometimes bizarre and frightening behaviors cannot be avoided. More specifically as a result of the stress of his inappropriate and unconstitutional institutionalization, J. R. has been subjected to a program of chemotherapy which has had and will continue to have long term detrimental physical and psychological effects on his development. His IQ has declined. He is stigmatized by the label of "mental patient" which has had profound repercussions on his self-image and self-confidence and which will continue to influence, overtly or subtlely, the manner in which he will be treated the rest of his life.

34.

In the opinion of experienced and competent psychiatric personnel, J. R. is suffering from institutionalization and needs immediate placement in a less drastic environment.

35.

J. R. has not been afforded periodic consideration for placement in the least drastic environment.

36.

J. R. has not been placed in the least drastic environment.

37.

Although the defendants have known or should have known of J. R.'s inappropriate placement, J. R. remains incarcerated against his will at Central State Hospital.

VIII.

STATUTORY FRAMEWORK

38.

Georgia Code §88-503.1(a) provides as follows:

> The superintendent of any facility may receive for observation and diagnosis any individual 18 years of age, or older, making application therefor, any individual under 18 years of age for whom such application is made by his parent or guardian and any person legally adjudged to be incompetent [9] for whom such application is made by his guardian. If found to show evidence of mental illness and to be suitable for treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.

39.

Pursuant to Georgia Code §88-503.1(a), a parent or guardian may "voluntarily" commit a juvenile to a state mental health facility regardless of a juvenile's opposition to admission. There is no provision in the Code for a hearing prior to admission to determine the appropriateness or necessity of such action. Nor is there anyone to protect the juvenile's interests in the admissions procedure. In effect, a juvenile is "powerless" to influence a decision which may result in his indefinite confinement in an institution.

40.

There is no statute, regulation, or policy which provides for periodic review and, where appropriate, placement in a less drastic environment, of juveniles committed pursuant to Georgia Code Annotated §88-503.1(a).

IX.

FIRST CLAIM FOR RELIEF

41.

By operation of the statutory scheme, plaintiffs and their class have been, are, and will be involuntarily committed to and incarcerated in state mental health facilities without being afforded a meaningful and complete opportunity to be heard. Consequently, defendants have deprived them of liberty without procedural due process of law in violation of the Fourteenth Amendment to the United States Constitution.

42.

By incarcerating plaintiffs and their class without initial and periodic consideration of placement in the least drastic environment, defendants have denied them liberty without due process of law in violation of the Fourteenth Amendment to the United States Constitution.

[10] X.

SECOND CLAIM FOR RELIEF

43.

As a result of the deprivation of their constitutional rights, named plaintiffs have been damaged in the amount of $10,000.00 each.

XI.

INJURY

44.

As a result of their unconstitutional commitments, the plaintiffs and their class have suffered severe and irre-

parable injury, and have no adequate remedy at law to redress the stated constitutional deprivations and wrongs. Plaintiffs and the class they represent will continue to suffer irreparable harm from the constitutional deprivations and wrongs set forth herein unless and until the declaratory and injunctive relief sought herein is granted by this Court.

XII.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs, on behalf of themselves and the members of their class, pray that this Court:

1. Enter an order convening a three-judge court, pursuant to 28 U.S.C. §§2282 and 2284 to determine the controversy.

2. Enter an order certifying this action as a class action consisting of all persons younger than 18 years of age admitted by their parents or guardians to state mental health facilities pursuant to Ga. Code §88-503.1(a) as provided by Rule 23(c)(1) of the Federal Rules of Civil Procedure.

3. Issue a temporary restraining order stating that the defendants shall place plaintiffs J. L. and J. R. in the less drastic environment suitable to their individual needs.

[11]

4. Enter an order that the trial of this action on the First Claim for Relief shall be advanced and consolidated with the hearing on the motion for preliminary injunction pursuant to Rule 65(a)(2) of the Federal Rules of Civil Procedure.

5. Issue a preliminary and permanent injunction enjoining the defendants from:

a. enforcing and executing Georgia Code §88-503.1(a) as it allows the commitment of persons younger than 18 years of age admitted by their parents or guardians without due process safeguards provided by the Fourteenth Amendment to the United States Constitution

b. accepting into a state mental health facility any person whose admittance is sought by his parent or guardian on a voluntary basis unless such person has been afforded prior to commitment the right to:

1. meaningful notice;

2. a hearing;

3. counsel and, if indigent, appointment of counsel;

4. present evidence and testimony on their own behalf;

5. subpoena witnesses and documents;

6. confront and cross-examine witnesses against them and those who wish them to enter a facility;

7. independent expert examination and assistance;

8. have the defendants show by clear and convincing evidence that hospitalization is the least drastic environment necessary for treatment, safety and care;

[12]

9. be involuntarily hospitalized only upon a decision that they are mentally ill and present an imminent likelihood of serious harm to themselves or others, being based on clear and convincing evidence;

10. be involuntarily hospitalized only upon decision of a disinterested and impartial decision-maker;

11. appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

12. other procedural safeguards.

c. failing to (1) immediately review the needs of each member of the class who is presently residing in the defentant's mental health facilities to determine their need for continued hospitalization and whether hospitalization is the least drastic environment for their treatment and (2) immediately place each member of the class in accordance with the findings of the review.

d. failing to (1) review the needs of each member of the class on a periodic basis and (2) immediately place each member of the class in accordance with the findings of each periodic review.

6. Enter a final judgment pursuant to 28 U.S.C. §§2201, 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that Georgia Code §88-503.1(a) is invalid, void and of no effect in that the statute violates the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

7. Award damages to plaintiffs J. L. and J. R. in the amount of $10,000.00 each for the unconstitutional deprivation of their civil rights.

[13]

8. Allow the plaintiffs their costs herein and reasonable attorneys' fees.

9. Grant such additional and alternative relief as may be deemed by this Court appropriate, just, proper and equitable.

Respectfully submitted,

/s/ DAVID GOREN
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[14]

GEORGIA, BIBB COUNTY

Personally appeared before the undersigned attesting officer, authorized to administer oaths under the laws of the State of Georgia, came affiant, who, after being first duly sworn, deposes and says that the facts and allegations set forth in the foregoing document are true and correct to the best of affiant's knowledge, information and belief.

/s/ DAVID GOREN
DAVID GOREN, GUARDIAN AD LITEM
FOR PLAINTIFFS

Sworn to and subscribed before me
this 24th day of October, 1975.

/s/ MILISSA H WALKER
Notary Public, Georgia, State at Large

My Commission Expires:
August 24, 1979

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

[Filed at 10:50 A. M., Oct. 24, 1975, Dorothy F. Motes, Deputy Clerk, U. S. District Court, Middle District of Georgia]

MOTION FOR CLASS ACTION, CONVENING THREE-JUDGE COURT AND PRELIMINARY INJUNCTION

Plaintiffs J. L. and J. R. move the Court to grant the following relief:

1. Issue an order pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure determining that this action may properly proceed as a class action pursuant to Rule 23(a), (b)(2) on the grounds that: the class, consisting of all persons younger than 18 years of age admitted to the defendants' mental health facilities upon the application of their parents or guardians, pursuant to Georgia Code §88-503.1(a), is so numerous that joinder of all members is impracticable; there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class has acted on grounds generally applicable to the class making appropriate final injunctive and declaratory relief with respect to the class as a whole.

2. Request the Chief Judge of the Circuit to convene a statutory court of three judges for the purpose of hear-

ing and determining this application for a preliminary and permanent injunction and this cause, in accordance with the provisions of Title 28 United States Code §§2281 and 2284 which require the [2] convening of such a court when an interlocutory and permanent injunction are sought to restrain a state officer from the enforcement of a state-wide statute that is alleged to conflict with the Constitution of the United States. The preliminary and permanent injunctions are sought to restrain the defendants, who are state officers, their successors in office, agents and employees, and all other persons in active concert and participation with them, from failing to provide to the plaintiffs and all persons similarly situated a meaningful hearing on their need for institutionalization and initial and periodic consideration for placement in the least drastic environment.

3. Issue a preliminary injunction pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining the defendants, their successors in office, agents and employees, and all other persons in active concert and participation with them from failing, pending a final decision on the merits, to give the plaintiffs and all persons similarly situated a meaningful hearing on their need for institutionalization and initial and periodic consideration for placement in the least drastic environment.

Plaintiffs seek this relief for themselves and all others similarly situated on the grounds that:

a. They and all others similarly situated are each suffering, or are imminently threatened with suffering, irreparable damage in that they have been or will be committed to the defendants' mental health facilities for an indefinite period without any meaningful procedural

and substantive safeguards to prevent inappropriate institutionalization;

b. The issuance of a preliminary injunction will not cause undue inconvenience or loss to the defendants but will prevent irreparable damage to the plaintiff and others similarly situated;

c. The statute [Georgia Code §§88-503.1(a)] that [3] deprives plaintiffs and all others similarly situated of their liberty violates the Fourteenth Amendment of the Constitution of the United States.

d. Plaintiffs have no adequate remedy at law, as set forth more fully in the verified complaint.

Respectfully submitted,

/s/ DAVID GOREN
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Attorneys for Plaintiffs

[1]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

TESTIMONY OF DR. WAYNE HODGES

Given in Hearing before Judge Wilbur D. Owens, Jr.,
in Macon, Georgia, on October 30, 1975

DR. WAYNE HODGES

Witness called by the Plaintiffs, first being
duly sworn, testified on

DIRECT EXAMINATION

BY MR. GOREN:

Q Mr. Hodges, please state your name and address.

A Wayne Hodges, 548 Comanche Drive, Macon, Georgia.

Q Could you briefly describe for us your vocational work and training especially in regard to children?

A I have a B.S. degree in psychology from Troy State [2] University, and I have an academic degree, M.A. in general theoretical psychology from East Carolina University. I have a Psy. D., a Doctor of Psychology, from Baylor University in clinical child psychology concentration. Have been at Central State Hospital since '68. Primarily my experience there has been with children. Also much of my practical training period and my formal academic training was with children.

Q Have you published any articles?

A I have, about ten or twelve.

Q Have you published any articles in relation to children?

A Yes, I have. I think at last count twelve professional papers. I suppose about half of those must be directly related to treatment of emotional disorders in children.

Q Have you had any internship training?

A Yes, with Joseph (inaudible) University Medical School for a year, in Philadelphia, Pennsylvania, and there, by request, my concentration training was with children.

Q Is that a special internship program?

A Yes. It is an international program accepting certain quotas from the States and certain quotas from foreign countries who have practitioners interested in furthering their education in behavior therapy under Dr. Borpe (??) who is known in our profession as the father of behavior therapy.

[3]

Q Doctor, could you please describe for us in general the effects of immediate and long term of inappropriate hospitalization of children.

A Well, the immediate effects seem to have to do with depersonalization and desocialization of persons thrown into these types of settings. I suppose I could narrow it down to generalities somewhat when I say these types of settings to pertain mostly to the State Hospital type of setting. Immediately there is the depersonalization that takes place, and some sort of conditioned emotional

responses that frequently occur from frustrations they are undergoing. There seems to be a period of time in which individuals may be exposed to inappropriate learning experiences so that by modeling he may adopt many of the other patients inappropriate behavior to his own repetoire, primarily due to a lack of alternatives given to him in his development to cope with stress. He readily takes on those behavior patterns that he sees as being a viable alternative for himself. Reaching a little further in terms of scope into the future, we find two sub-groups of patients that usually evolve due to institutionalization. I base my opinion at this time primarily on the work of Gogden and if I am not mistaken a fellow named Base has also done some work in therapy, but it's been a long time since college exams, so the names may not be exact. But he has found that the two groups are those [4] patients who tend to become colonized and then those patients who tend to organize to try to beat the system. The colonization of patients seems to be the one resulting in the most detriment to the patient, since they essentially become a very dependent species, unable to take care of themselves independently in the regular mainstream of life.

Q Do these effects become more pronounced as the state in the hospital progresses?

A If you mean more pronounced in terms of their prognosis, yes. Although of course the height or intensity of the maladaptive behavior of course may not go beyond that after a certain number of years. But in terms of the increase of the—in terms of the prognosis, continuance of hospitalization will make the prognosis progressively poor because tendencies grow with time and with practice and a very strong habit that's maladaptive will be much more difficult to treat, and will have far-reaching effects

in terms of any intervention that you might try with the patient. I might add that all of these factors allow for the original behavior of the person and the original disorder they first presented themself with to sort of multiply and intertwine so that as previously I have stated at one time, they became somewhat panicled with the original problem and solving the thing becomes rather difficult.

Q Are these effects more exaggerated when dealing with [5] children as opposed to adults?

A In terms of prognosis I would say certainly, because you see with adults much of our treatment has to do with the breaking down of inappropriate behavior, and then attempting to instill an alternative. With children, due to age, and due to familial reasons due to environmental reasons, they never actually develop the behavior and appropriate responses in the first place, so that they are highly susceptible to implementation of much behavior that otherwise they would not have, since they are in a learning process, so that treatment then becomes not only one of breaking down—it also becomes one of instilling and giving alternatives, so that it is a two-fold process with children. Then if appropriate treatment isn't given, by the time that child spends a great deal of time in such an environment in an institution, we may find that the process of breaking down is very difficult because he has had time to model from a myriad of behaviors, and we may find the process of giving alternatives to be very difficult because he has ingrained a great many mutually exclusive inappropriate behaviors that work against any therapeutic behaviors that we try.

Q Would you describe your present job and your duties and responsibilities in that job?

A Theoretically I am clinical director of psychology. I am also—in terms of duties—this has to do with monitoring [6] and carrying on all functions of professional psychology.

Q Is that at Central State Hospital?

A Yes. There is a more recent name for it—Central Georgia Regional Mental Health Center. Then I have teamly functions, which—on the girls ward—which essentially a synthesized function of all ward activities and serve as consultant to attendant staff and so forth in dealing with patients and to assist the ward physician with planning and disposition of patients, and as conceived is mainly an active day to day on the ward monitoring and intimate involvement with all patient activities, intake, treatment, disposition, and so forth. In terms of job title, I suppose this is it. I am also involved in various other activities.

Q Doctor, are you familiar with a study done in 1973 on Central State Hospital's facilities for children and adolescents?

A Cursorily.

Q What I would like to do, Doctor, is to retrieve from that study their recommendations, conclusions, and see if you agree with it in regards to the facilities at Central State Hospital. Recommendation A—there are not adequate facilities to serve the present need at Central State, therefore it is essential that the new regional hospitals begin child services as soon as possible, and children at Central State from geographical areas having hospital [7]services be transferred.

A Yes, I am familiar with that.

Q Do you agree with the statement?

A Is that the No. A? Yes, I agree.

Q The second statement—

THE COURT: Mr. Goren, wouldn't it be appropriate to first, for the Court's information, remembering that the Court known nothing about the facilities, just to give us a basic description of the physical facilities over there for children? You may not want to do it with him, but that's something the Court needs to know, to be able to understand anything about the problem.

MR. GOREN: O.K. What we will do, Your Honor, is ask Dr. Hodges to explain his agreement with these conclusions in regard to the specific facilities at Central State.

THE COURT: All right. Just bear that in mind.

Q Mr. Goren: Dr. Hodges, the second of the conclusionary recommendations is that plans should begin now for closing the 80-bed adolescent unit, as a physical facility completely unacceptable for therapeutic rehabilitation for young children.

MS. KIRKLEY: Your Honor, I object to his [8]answer that until he has laid the foundation showing that he knows that facility—

THE COURT: Doctor, are you familiar with the 80-bed facility in question?

THE WITNESS: Are you talking about the C & A unit?

MR. GOREN: Yes sir, the adolescent unit.

THE WITNESS: Yes sir.

THE COURT: All right. Let him describe the unit.

Q Mr. Goren: Dr. Hodges, explain why you are familiar with that unit and your description of that unit, please.

A Well, administratively I am not familiar with the ins and outs of it. But in terms of the physical plan and at least the low level of administration, I am familiar with it. We have part of the Boland Building which is one of the older buildings, for the adolescents, and I don't know how many beds we actually have in those. The childrens building is a new building and very nice in terms of physical accomodations as it now stands and as it now functions, and that is primarily for the treatment of children. The adolescents and children are separated.

THE COURT: What's the difference in an adolescent and a child as you use that term?

[9]

THE WITNESS: Your Honor, could you be a little more specific?

THE COURT: You differentiate between children and adolescents.

THE WITNESS: In the sense that I use it?

THE COURT: Yes sir.

THE WITNESS: I think over 12 years—I think I should answer that not from a professional viewpoint but from the viewpoint of how the C & A unit is run. 13 and up are considered adolescents and are placed in the adolescent ward, and those below that age, children.

THE COURT: Doctor, go back and give me a basic description of the buildings where these children are housed—are they housed in one room, or in separate rooms, or how?

THE WITNESS: O.K. In the adolescent unit the male and female wards are separated by a lobby. Within the ward itself there is separation by a metal gate into two different areas. There is common bedroom facilities for the in patients. The beds are in sort of, I suppose, a Belaire arrangement in terms of having no partitions between them—sort of open.

THE COURT: Are they cots, or double deckers?

THE WITNESS: They are Army bunk type beds [10]—not bunk beds one on top of the other, but they are individual beds, maybe a little bit less than twin size—they remind me of Army barracks type of bed. Then outside of the bed area there is a sort of day room area which essentially is probably a 30 x 10 feet area in size, in which there is TV and couches along the wall for them to collectively spend their day if they choose to watch TV and to interact in that way. It's a flat roof structure, the walls are fairly well painted right now, have various posters on them for cheering up the guys, and there are—there is one doctor's office there on the ward which is toward the far end of the ward, near the outside lobby. The secretary is away from that office so that work can be done, due to the noise from TV and activities of the patients if they are near the office area. It's tile floor. In the center of this complex I have just described is a nurses' station which attending ward personnel house their administrative functions.

Q Mr. Goren: Doctor, could you now explain why these facilities lead you to agree with the conclusion which I read earlier?

MS. KIRKLEY: Excuse me. I believe he just described the adolescent unit.

THE WITNESS: Yes, I did.

[11]

MS. KIRKLEY: And did not describe the children's unit.

THE COURT: Describe that also.

THE WITNESS: The children's building is separated also. The entire building is split in a sense down the middle, and separates male from female sides. The interior there reminds me very much of a dormitory life sort of setting. There is a sort of bright atmosphere as compared to the adolescent ward—lots of bulletin boards. It is a new building and it's well kept and there's lots of activity going on there professionally, activity such as music therapy, and the kids can wander in there occasionally which I have seen them do. The sleeping area seems to be recognized as dormitory like. Again they have more privacy in that the sleeping area if I recall correctly is divided off into separate rooms.

Q Mr. Goren: Doctor, have you had an opportunity to examine and review the case records of plaintiff J. R.?

A Yes.

Q First of all, what unit is J. R. in?

A Adolescent 7.

Q That was the first unit you described?

A Yes.

Q And based on your examination and your review of [12] J. R.'s case history, have you been able to form an opinion as to his need for further hospitalization?

A Yes. I would like to state as I have previously that I am not familiar with the record in every exacting detail.

I have reviewed the record and followed it in sort of a chronological order and was able to form a diagnostic impression, an impression of what disposition would be most appropriate. But I don't want to purvey the idea that I have an infallibility, an infallible intimacy with his record. Would you please repeat the question?

Q Have you also personally examined J. R.?

A Yes. Well, I saw him for about 15 to 20 minutes interview.

Q Based on that interview and perusal of the record which you just described, were you able to form an opinion as to his need for further hospitalization?

A Yes. Also I talked with the team leader from his ward area who has a very close working knowledge of the boy. This constitutes partially the basis for my opinion. I feel like that J. R. is just a mildly retarded individual who needs structure and supervision but could function much better in a setting characterized by a heck of a lot less structure, and that would afford him more appropriate opportunities for him to develop his self-supporting skills as he grows older.

[13]

Q Would continued hospitalization of J. R. be harmful to him?

A I believe that it would, for the reasons that I stated earlier. A boy this age is easily led and with his limitation in ability he would be as highly susceptible to suggestion, who also—many kids who have a history like this also in a sense are affection hungry so that they will do things for mere peer attention and pure acceptance. So that what I am saying overall is that it would be fairly easy for them to incorporate a great many inappropriate behavior to his

own repetoire, that would lead us to characterizing him as being pretty maladjusted, plus, as I mentioned earlier, the habit strength of these individuals increase with each day, just making it more difficult to ever break them down and instill new behaviors. The third consideration is that this type of child is an excellent type of candidate for colonization, as I earlier explained as being taken from Gogden's research.

Q Colonization being what?

A Colonization being development of very dependent type personality, one that is "a good patient" and looks to ward life structure and guidance for his existence from minute to minute and cannot function independently from the ward structure, and in patient hospital structure. They are institutionalized is also another term frequently used to describe this type of patient.

[14]

Q You are saying that each day he is there he is susceptible to becoming more institutionalized and therefore will have lesser of a chance of succeeding on the outside?

A Yes.

Q Do you have a recommendation for what alternative placement would be appropriate for J. R.?

A Well, this is a very difficult question, because it has to do with the alternatives available. So that while one could certainly say the present setting is not the optimal one and in many respects could be detrimental, it's not easy to put your finger on what would be most appropriate. I am also impaired somewhat by my lack of knowledge in toto of what Georgia offers. I will try to answer your question after all this qualification. A specialized foster home setting could possibly do it. A smaller group home setting, such as a Boys Ranch where he would get structure and some objectives from day to day, something to do with guys, maybe work pretty hard during the week, with lots of interaction and stimulation, maybe fishing on the weekend, a camping trip, or something like this—a much less structured and more healthy optimistic type thing.

Q Now back to Plaintiff J. L.—

THE COURT: Before you leave J. R., what do you mean by slight mental retardation?

THE WITNESS: A mild retardation. This is [15] characterized by a deficiency in scope and skills and intelligence level is somewhere around 65 to 75. These kind of people usually are—they are not stupid, but they are rather slow. They make good solid citizens. They work hard, see after their own business, like to go to town on Saturday afternoon to a movie, but they never pursue academic skills. They just are people who can function, not very brightly, but nevertheless they are not severely impaired.

THE COURT: Let me ask you—from your review of his record, do you perceive that had he existed in a normal parental situation that he could have survived in the public school system of this State? If he had caring parents who sent him to school like everybody else does?

THE WITNESS: I believe not without special resources—resource teachers or special education classes.

Q Mr. Goren: One more thing about J. R. This function that you just described for people who are the same level of retardation that J. R. is presently at, would his continued hospitalization harm his chances of being

able to fulfill his potentials for somebody of his intellectual capacity?

A Yes, for that reason, that is the intelligence reason. [16] And of course for other reasons whethera person is mildly impaired or not, their behavior is determined not only by an inherent or low I.Q. level but by the opportunities afforded them. We have indication that not only is it a matter of having opportunities afforded, but if they do not occur at a certain time and in a certain way then the person may be permanently impaired from incorporating this into day to day functions. In other words, if a person doesn't learn how to learn sometimes, they can't even learn later even though they normally would—so that you may have instilled sometimes a situation whereby a person's ability to further incorporate is harmed.

THE COURT: Doctor, what do you perceive other than the slight mental retardation to be the cause for this child being kept in this facility, Central State Hospital, during the time he has been there?

THE WITNESS: I think primarily a lack of alternatives for more appropriate treatment. I think that is the primary reason.

THE COURT: Are you saying that from your review of the record that you gather that the State just had no place else to put this child?

THE WITNESS: I wouldn't say that they had no other place, but apparently it seemed to the people involved in the case at the time that this was the most [17] suitable alternative that they had to offer.

Q Mr. Goren: Doctor, have you also had an opportunity to examine J. L. and review his record?

A Yes.

Q And what ward is he on?

A He is on the male side of the children's unit.

Q Have you had an opportunity to form an opinion as to his need for further hospitalization?

A Yes.

Q What is that opinion?

A I believe more suitable arrangements could be made, possibly specialized foster care situation. It must be understood that frequent professional treatment should be carried out by the prospective foster parents for a more optimistic future there would need to be counseling continued.

Q What would be the effect on J. L. if he were required to remain hospitalized?

A It's my opinion that with this particular boy he seems to have a little get up and go about him. I don't think that he would become colonized. I think he would become one who would attempt to beat the system and would become very hostile, aggressive, and begin to show his displeasure and aggravation by a large number of responses that could make him be sort of obnoxious. Particularly a kid with his intelligence level and knows what's going on, there will [18] be an increased tolerance threshold so that you begin to see additional emotional responses occur that add to the problem, the additional emotional responses being simply a generalized emotion—a sort of frustration situation, and they may become sort of patterned or attached to various functions socially and so forth so that they come out and become visibly as part of the psychological problem.

MR. GOREN: I have no further questions.

THE COURT: What do you perceive to be the reason for J. L.'s being admitted and being kept in this facility?

THE WITNESS: I guess it would be kind of like what we had on the other—lack of alternatives. What do you do, if we put ourselves in the place of the individuals who are dealing with the child at the time. The familial situation was unstable, there was a traumatic point and the child had reacted to this with a good deal of frustration, irritability, hyperactivity, the school couldn't handle him, the family couldn't handle him, and no one wanted him.

THE COURT: He is just seven?

THE WITNESS: Yes. It's not unusual to see hyperactive reaction in children exposed to a traumatic situation.

THE COURT: What—I know what I think that [19] term means, but how do you use that term?

THE WITNESS: Well, the child is usually one who has a very short attention span, won't pay much attention to anything for an appreciable period of time. He is eternally from one thing to another. He is easily upset and aggravated. You can't get him to settle down, he's hard-headed, won't listen to you.

THE COURT: Sounds like my four-year old.

THE WITNESS: I could put that into other language, but I feel like that describes it as much as anything else.

THE COURT: Do you consider that to be an abnormal trait of children at 7 years of age?

THE WITNESS: To the degree it was being shown, it was abnormal when you compare it to normalcy. When you go to talking about abnormality, there are five different ways pathologists characterize this term. In the sense that you just mentioned it, you are speaking in reference to a known. That is, how does this child's behavior compare to an average. If we look at it in that sense, I think possibly we would have to say that his behavior exceeded the intensity and amplitude of those kinds of behaviors seen in normal people. If you look at it from the sense that is the behavior abnormal given the circumstances in which it evolved, I [20] would say no, it is quite normal behavior for child of that age to display given the situation.

THE COURT: And what do you perceive to be the mental level of J. L.?

THE WITNESS: How smart he is, Your Honor?

THE COURT: Yes.

THE WITNESS: He is average intelligence.

MR. GOREN: Just a few more questions, Doctor.

Q Mr. Goren: In children who are admitted to the hospital, do you often find that there is stress within their family situation?

A Would you remind repeating that?

Q Children like J. L. who are admitted to the hospital, do you often find in the history of children like this that they come from a stressful family situation?

A Yes. Very much.

Q Does that often lead to their hospitalization?

A Yes. I think that implied in this kind of question you are asking is something that has been battered about for years in our field, and that is—well, I will just give a conclusion. It's now inconceivable that we could try to determine the abnormality in the absence of considering the situation in which it occurred. You say is there a stressful family situation associated—well, there must be [21] some situation associated because little has been done in the science of psychology sans disorders directly connected to some physiological or organic basis. Then we must always, at least from my viewpoint, consider that a disorder can develop in the sense of some learning process by some pathological lesion forming, by a constitution which it itself can also be involved. And the third way is by learning, which is by far the biggest reason for our behavior.

Q To treat children who come from that kind of family situation, is it necessary also to work with the family?

A Yes.

Q And what would be the effect if there wasn't any family to work with?

A The question you always ask in the treatment of a child in your consideration of when he should go back, when should he be entered back into the community, is how many of the relevant precipitating elements were altered by the treatment. If none have been altered, and if the behavior had its beginning in this situation, and you haven't altered any of the elements, you almost have to predict that the same thing is going to occur.

THE COURT: Doctor, in what proximity are the physical facilities that you described to the adult facilities? Physical proximity.

THE WITNESS: Judge, I would say a half to [22] three-quarters of a mile.

THECOURT: From the nearest facility?

THE WITNESS: I believe that's right.

THE COURT: What opportunity is there for the children to get outside the building you described and onto the grounds?

THE WITNESS: They do have activity therapy and they are given opportunity to go out on a daily basis. This is determined partly by the particular problem of the individual and the amount of ward help available for monitoring the children. But at least as it is set up all of them have opportunity to go out if their behavior and the circumstances let them go out.

THE COURT: Is there any type schooling?

THE WITNESS: Yes sir. There is a special education school that is directly connected with the hospital and is actually in the same building with the adolescent unit.

THE COURT: All right.

CROSS EXAMINATION

BY MR. LACKEY:

Q Doctor, without being unduly repetitious, I would like to begin again with the physical facilities, if I might. It is true that J. L. is located in the children's facility at this time, isn't it?

[23]

A Sir?

Q It is true that J. L. is located in the children's facility at this time, isn't he?

A Yes, that's right.

Q And that J. R. is located in the adolescent facility?

A Yes, that's right.

Q Let's talk about the children's facility. You used the term dormitory, school dormitory.

A Yes.

Q Is it departmentalized?

A Yes, it is.

Q And you say there's always activity going on there?

A Yes, I think that's fair to say.

Q Is there a professional staff available there in that facility?

A Yes, there is.

Q What type of staff—just very briefly.

A We have attendants, nursing personnel, activity therapists are available from time to time, there is a psychology staff there for contact with the patients.

Q In other words there is a full range of psychiatric services there?

A Yes.

Q From psychiatrists on down to attendants?

A Yes. If you would like to use that ladder.

[24]

Q Just going through the range, from people who are there the most to people who are there the least. There are play areas for the children at this facility, aren't there?

A Play areas?

Q Play areas—entertainment areas.

A Yes.

Q There are recreation facilities available to them. Swing sets and that sort of thing?

A Yes sir, they've even got an old hook and ladder from an antiquated fire engine.

Q Now in the adolescent unit—by the way, do you know how many children are in the children's unit today?

A I am not able to answer that. It's under 20 and maybe over 10.

Q Let me break that down. Under 20—does that include male and female?

A I believe that's right.

Q And they are separated by sex?

A Yes.

Q So that means that following normal percentages there are probably 10 male children and 10 female children?

A Yes.

Q So the males interact in a group of 10 and the females in a group of 10?

[25]

A Yes. Like I say, I can't be specific.

Q And they have a school right there in the building?

A From the children's building the school is just a short walk. Yes.

Q There is a school available.

A Yes.

Q Are they required to attend and perform to their abilities?

A Yes.

Q Is this a highly specialized school?

A It is a special education school and offers a curriculum to my knowledge fairly representative of special education schools. I don't know really how to respond to that.

Q Are these special education type schools available everywhere in the State, to your knowledge?

A To my knowledge they are.

Q The way you answered that is that that you don't know, or—

A That probably would be the best answer. My wife is a teacher, we've been all over, I guess. Most schools have special education, and I think this is sort of set up by legislation and governed by the educational system.

Q You spoke of models when you were discussing some of the problems of children. Do the male staff members act as models for the children under normal circumstances?

[26]

A If you mean by models in the form of therapeutic sense I would say no. Of course any live person is a model whether it is by intent or whether it be inadvertent.

Q And one more question about the children—are they fed regularly three meals a day, this sort of thing?

A To my knowledge they are. They all seem to look healthy.

Q Let's talk about the adolescents. The physical layout as I understood it, in this case there are different wings for the males and females?

A Yes.

Q And as I understood you, each wing is again divided in at least two sections?

A Yes.

Q How many children would you presently say are in the adolescent building?

A Male and female?

Q Yes.

A I would say close to 40—give or take 2 or 3.

Q And again using the normal percentages I would say there are approximately 20 males and 20 females?

A Yes.

Q And the wards are divided—I assume they are separated into even smaller groups again?

A Depending on how things are going. They may be and [27] may not be, but they have that potential.

Q They could be divided—assuming they were divided equally, there would be 10 in one group and 10 in the other?

A Yes.

Q Do they have recreational facilities available in the adolescent ward? I know you described the place, but I am more interested in the outdoor type—

A Yes, there is—the building is constructed so that in the physical layout of it, the building is such that there is a

quadrangle enclosed, in the building itself. They get out in there. I must say the recreational facilities as I described for the children I think are probably more adequate than they are for the teenagers, because here you have a different set of needs for recreation, and I must say that the physical facilities for their recreation is not that good. We do have activity therapy and we have recently added occupational therapy.

Q Do you have therapists who deal with music?

A Yes.

Q What other kind of therapists do you have available?

A There is recreational therapists.

Q Are all these therapists—

A And there is occupational therapy, which is servicing a very limited number of the patients.

Q There are for these adolescents various types of [28] therapy available and for the children also?

A Yes. There is. There is some amount—but I don't feel competent saying at this time that it is adequate.

Q The point I am getting to, Doctor, and that I am trying to make to the Court is that we are not keeping them caged over at the Central State Hospital, each in his own little place, with no stimulants or anything else, are we? We are providing some sort of services?

A Yes.

Q There is professional help provided?

A We make every effort for that to be so. In some cases that is not possible.

Q Now let's talk about your diagnosis—let's go back—you gave us quite an impressive list of credentials. When did you finish your formal training in this area?

A August 16, this year.

Q August 16 of this year? Is that when you rejoined the hospital on a full time basis?

A Yes.

Q So you just in essence finished your formal education?

A Yes.

Q And embarked on your professional career. Is that the case?

A Yes.

[29]

Q And did I understand you to say that you had—

MR. LACKEY: Your Honor, is it appropriate for me to use the first names of these children? We've been doing that all day.

THE COURT: I think so. Yes.

Q Mr. Lackey: It's my understanding from our conversation earlier in which you testified today that you had seen Jimmy for approximately 20 minutes.

A Yes.

Q And for Joey you had seen him approximately 20 minutes in an interview situation and on other occasions in a perfunctory manner. Is that correct?

A That's right.

Q So in essence, I take it,—and you also read the files on the two boys?

A Yes.

Q Now isn't it true then that basically what you told us all today is based on not your study of these two cases but on your general theory of how children should be handled—children with emotional problems should be handled?

A No sir, I don't feel that is is. I also would like to add to the two aspects that formed the basis, and that is my third point that I talked with a member of the psychology staff in the children's unit about J. L. to add to my readings. I also talked with the team leader on adolescent 7 about [30] J. R. to supplement my reading, so that not a great deal existed on the theoretical level. I do have to say I based it on the basis of my professional opinion.

Q In that case what you must be saying is that there are children there that you think should remain in that institutionalized situation?

A Yes sir.

Q Are you familiar with the social background of these two children from your review of the record?

A Not in great detail. I am in terms of the sort of unstableness of the situation—this type of thing, and I know I would be very vulnerable to questions or specifics in that area.

Q I take it then you are not aware that J. R. has been sent to a foster care type situation at least nine times or ten times since he was originally brought to Central State Hospital?

A I was not aware of that.

Q Let's talk about your diagnosis again—you diagnosed one of the children as being mildly retarded. Doesn't the case record indicate that this child also had emotional

problems, throws temper tantrums, head-banging, bed-wetting?

A Yes.

Q Aren't those all symptoms of some sort of emotional [31] disorder?

A Yes, they are.

Q Something besides mental retardation?

A Yes.

THE COURT: Head-banging and bed-wetting are symptoms of what?

THE WITNESS: As the lawyer said, of further emotional disorder, if it's intense enough, and I assume that he mentioned that in that context—

MR. LACKEY: I was reviewing the record where it was reported that he threw temper tantrums, head-banging, bed-wetting, this sort of thing.

THE WITNESS: And your question was are these sometimes symptoms of other emotional disorders. Was that your question?

MR. LACKEY: Yes.

A The Witness: Yes, these are sometimes symptoms of other emotional disorders, particularly with emphasis on the intensity.

THE COURT: They are also symptoms of a normal child, aren't they?

THE WITNESS: That's true.

THE COURT: I have known of many children that do the same thing—normal children that live up and down the street.

[32]

MR. LACKEY: In his medical records these were given as part of the reason at the time of his admission.

THE COURT: That's what's disturbing to the Court.

MR. LACKEY: Well, the Doctor has said this demonstrates some emotional disorder.

THE WITNESS: I said sometimes. Let me talk for a minute if I may, about the problems of diagnoses.

THE COURT: Let's don't do that. Go ahead.

Q Mr. Lackey: You mentioned you thought the idea for these people would be specialized foster care? Is that correct?

A For J. R. I think I said either that or a group home setting with sort of a more optimistic atmosphere, such as a Boys Ranch.

Q Just assume for the moment that a Boys Ranch is available—I don't know that it is—what is different—as I understand it, a Boys Ranch type situation is again a group setting of a number of persons who are in a ranch type setting. They are still in a group, and I assume that the group would be no smaller than the ten we are talking about here. What makes that situation any more different so as to warrant setting up a special system?

[33]

A I have to speak from my experience and my context of what is a Boys Ranch, at least from my understanding, it's based on a home type existence in which the kids are not depersonalized in that they can have their own personal items, they have their own beds in a rather private area. They can more or less go and come at will, but they have specific tasks.

[34]

Q I take it you mean then out of the professional setting—by home setting you mean a typical foster care setting with just ordinary people running the situation for the child as opposed to a psychologist or social worker or something like that?

A Yes.

Q You are not talking about the professionals that we can go out and hire on the street?

A No.

Q You are talking about somebody who really cares about kids and wants to do something for them?

A Yes.

Q Do you know where the is a list—where there is a group of people like that that we can draw?

A No.

Q Isn't it the same way with specialized foster homes? Isn't the main ingredient the people—the person, the foster parents?

[34]

A Yes. And there are hardly any homes available, particularly for this age group.

Q And that isn't something money can cure, is it?

A Well, I think it probably is, because it seems that the level of values is very very intimately associated with social economic power.

Q You mean if the Judge raises the anti high enough we will find some of this parential love out there?

A I think it would flourish.

Q Is that what you want for the children? That kind of parental love?

THE COURT: Well, that—let's get off that.

MR. LACKEY: No further questions, Your Honor.

REDIRECT EXAMINATION

BY MR. GOREN:

Q Would the behavior of these children deteriorate if they remain hospitalized?

THE COURT: I think he has already answered that question. In his opinion continued hospitalization would be detrimental.

MR. GOREN: That's all.

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

(Caption omitted in printing)

[1] [Filed at 9:30 A. M., Nov. 18, 1975, Dorothy F. Motes, Deputy Clerk, U. S. District Court, Middle District of Georgia]

O R D E R

This confirms the court's verbal order of October 30, 1975, pursuant to Rule 23, Federal Rules of Civil Procedure, that this action is to be maintained as a class action. The class consists of all persons younger than 18 years of age now or hereafter received by any defendant for observation and diagnois and/or detained for care and treatment at any "facility" within the State of Georgia pursuant to 1969 Georgia Laws page 505, 517, informally codified as 1933 Georgia Code Annotated § 88-503.1. The representatives of the class are "J.L." and "J.R." by their guardian ad litem David Goren, Esquire. The present basis for this action so proceeding is Rule 23(b)(2). This order is conditional and may be altered or amended before a decision on the merits.

SO ORDERED, this the 17th day of November, 1975.

/s/ WILBUR D. OWENS, JR.

WILBUR D. OWENS, JR.
United States District Judge

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

[1]

DEFENSES AND ANSWER

COME NOW all defendants and make the following defenses and answers to Plaintiffs' complaint.

DEFENSES OF LAW

1.

The Complaint fails to state a claim upon which injunctive or declaratory relief may be granted.

2.

The Complaint fails to state a claim upon which monetary relief may be granted.

[2]

ANSWER

Responding to the specific allegations of the Complaint, the defendant show the following:

1.

Defendants admit that plaintiff seeks declaratory and injunctive relief, and damages for violation of their civil rights resulting from the operation of Ga. Code § 88-503.1. Defendants also admit that the cause of action arises under 42 U.S.C. § 1983 and that since an injunction of a statewide statute is requested that a three judge court is required. Defendants deny the remaining allegations of paragraph one (1) of the Complaint.

2.

The allegations of paragraph two (2) of the Complaint are admitted.

3.

The allegations of paragraph three (3) of the Complaint are admitted.

4.

Defendants admit that plaintiff J.L. is a citizen of Georgia age 12 who was admitted to the hospital upon application by his adoptive mother and stepfather pursuant to the challenged statute, Ga. Code § 88-503.1, and also admits that plaintiff J.L. would testify that he is being held against his will.

5.

The allegations of paragraph five (5) of the Complaint are admitted and defendants show by way of further answer that there was not an adversarial proceeding prior to the plaintiff's J.L. admission because he was voluntarily admitted pursuant to [3] the challenged statute, Ga. Code § 88-503.1, and also admits that plaintiff J.L. would testify that he is being held against his will.

6.

Defendants admit that plaintiff J.R. is a citizen of Georgia, age 12, who was committed by the Stephens County Department of Family and Children Services pursuant to Ga. Code § 88-503.1 and defendants further admit that plaintiff J.R. would testify that he is being held against his will.

7.

The allegations of paragraph seven (7) of the Complaint are admitted and defendants show by way of further an-

swer that there was not an adversarial proceeding prior to the plaintiff J. R.'s admission because he was voluntarily admitted pursuant to the request of his adoptive mother and after examination by the admitting physician at Central State Hospital (now Central Georgia Regional Hospital).

8.

The allegations of paragraph eight (8) of the Complaint are admitted.

9.

The allegations of paragraph nine (9) of the Complaint are admitted.

10.

The allegations of paragraph ten (10) of the Complaint are admitted.

11.

The allegations of paragraph eleven (11) of the Complaint are admitted.

[4]

12.

The allegations of paragraph twelve (12) of the Complaint are admitted.

13.

The allegations of paragraph thirteen (13) of the Complaint are admitted.

14.

The allegations of paragraph fourteen (14) of the Complaint are admitted and defendants show by way of further answer that plaintiff was diagnosed by the admitting physician as a hyperkinetic child and that he had unsocialized aggressive reaction of childhood.

15.

Defendants admit that plaintiff J.L. was admitted by adoptive mother and stepfather. Defendants can neither admit nor deny the remaining allegations of paragraph fifteen (15) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

16.

The allegations of paragraph sixteen (16) of the Complaint are denied.

17.

The allegations of paragraph seventeen (17) of the Complaint are admitted except defendants show that administrative procedures were used to determine the appropriateness of hospitalization and plaintiff was voluntarily committed to the hospital and therefore [5] was not the subject of an adversarial proceeding.

18.

Defendants admit that J.L. was confined in Central State Hospital from May 18, 1970 through September 18, 1972 when he was released on furlough and after that furlough he has been continually confined since that day. Defendants can neither admit nor deny the remaining allegations of paragraph eighteen (18) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

19.

The allegations of paragraph nineteen (19) of the Complaint are admitted accept that Defendants show by way of further answer that a relinquishment to Central State Hospital is not a legally binding document.

20.

Defendants deny that J.L. has been ~~in~~appropriately or unconstitutionally institutionalized. Defendants can neither admit nor deny the remaining allegations of paragraph twenty (20) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

21.

Defendants admit it would be appropriate for plaintiff J.L. to attempt to live in a less drastic environment, in a specialized foster home for example but show by way of further answer that at the present time they know of no specific foster home available for plaintiff J.L. Defendants can neither admit nor deny the remaining allegations of paragraph twenty-one (21) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

22.

The allegations of paragraph twenty-two (22) of the Complaint are denied.

[6] 23.

The allegations of paragraph twenty-three (23) of the Complaint are denied and defendants show by way of further answer that plaintiff J.L. is presently in the least drastic environment which is available for his care and treatment.

24.

Defendants admit that J.L. remained confined at Central State Hospital apparently against his will but they deny the remaining allegations of paragraph twenty-four (24) of the Complaint.

25.

The allegations of paragraph twenty-five (25) of the Complaint are admitted except that defendants would show that plaintiff J.R. was, at the time of his admission, mildly retarded or had a borderline normal level of intelligence.

26.

The allegations of paragraph twenty-six (26) of the Complaint are admitted except that defendants can neither admit nor deny that plaintiff J.R. lost his place in six foster homes to a more favored child for want of information sufficient to form a belief as to the truth or falsity of the allegation.

27.

Defendants admit that plaintiff J.R. would testify that he does not wish to stay at Central Georgia Regional Hospital. Defendants can neither admit nor deny the remaining allegations of paragraph twenty-seven (27) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

28.

The allegations of paragraph twenty-eight (28) of the Complaint are denied.

[7] 29.

The allegations of paragraph twenty-nine (29) of the Complaint are admitted except defendants show that administrative procedures were used to determine the appropriateness of hospitalization and that plaintiff J.R. was voluntarily admitted to the hospital and therefore was not given an adversarial hearing.

30.

Defendants admit that it would be appropriate to try to place J.R. in a specialized foster home and that none has been available since that time but defendants can neither admit nor deny the remaining allegations of paragraph thirty (30) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

31.

The allegations of paragraph thirty-one (31) of the Complaint are admitted.

32.

The allegations of paragraph thirty-two (32) of the Complaint are admitted.

33.

Defendants deny that J.R. has been inappropriately or unconstitutionally institutionalized. Defendants can neither admit nor deny the remaining allegations of paragraph thirty-three (33) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

34.

Defendants can neither admit nor deny the allegations of paragraph thirty-four (34) of the Complaint for want of information sufficient to form a belief as to the truth or falsity thereof.

35.

The allegations of paragraph thirty-five (35) of the Complaint are denied.

[8] 36.

The allegations of paragraph thirty-six (36) of the Complaint are denied and defendants show by way of

further answer that plaintiff J.R. has been placed in the least drastic environment available for his care and treatment.

37.

Defendants admit that J.R. remains confined at Central Georgia Regional Hospital and that he would testify that he is confined against his will. Defendants deny the remaining allegations of paragraph thirty-seven (37) of the Complaint.

38.

The allegations of paragraph thirty-eight (38) of the Complaint are admitted.

39.

Defendants admit that pursuant to Ga. Code § 88-503.1(a) a parent or guardian may voluntarily commit a child to a state mental health facility regardless of a child's opposition to admission and that there is no provision in the code for a hearing prior to a voluntary admission to determine the appropriateness or necessities of such action. Defendants deny the remaining allegations of paragraph thirty-nine (39) of the Complaint and show by way of further answer that the admission procedures protect the child's interest and that in this manner the child is able to influence the decision which results in his admission to an institution.

40.

The allegations of paragraph forty (40) of the Complaint are denied.

41.

The allegations of paragraph forty-one (41) of the Complaint are denied.

[8]

42.

The allegations of paragraph forth-two (42) of the Complaint are denied.

[9] 43.

The allegations of paragraph forth-three (43) of the Complaint are denied. Defendants jointly demand a jury trial on all issues of disputed fact with regard to plaintiffs' second claim for relief for ten thousand dollars ($10,000) damages for each of the named plaintiffs.

44.

The allegations of paragraph forty-four (44) of the Complaint are denied.

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ROBERT S. STUBBS, II
Chief Deputy Attorney General

/s/ DON A. LANGHAM
DON A. LANGHAM
Deputy Attorney General

/s/ TIMOTHY J. SWEENEY
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DOROTHY Y. KIRKLEY
Assistant Attorney General

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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

(Caption omitted in printing)

[1] **AFFIDAVIT OF JANET SCOTT**

I, Janet Scott do hereby swear or affirm the following to be true.

I presently reside at 240 Richards Drive, Milledgeville; my mailing address is P.O. Box 1076, Milledgeville, Georgia.

I have a Masters Degree in Social Work and am presently employed by Central State Hospital, Milledgeville, Georgia, in the position of Social Worker III.

From August 1968 through March 1971 I was the Social Worker in the Children's Building, part of the C & A Unit, of Central State Hospital.

I first came into contact with Joey Lister in March 1970, as an out-patient. It was my understanding that his step-father had contacted Col. Schuyler, who in turn contacted Dr. Portuondo, Unit Director, C & A Unit regarding out-patient services. On March 17, 1970 I had my first meeting with Joey and his parents on out-patient status. I met with Joey and his family approximately once per week, for about two months, while he was on out-patient status. These meetings consisted of individual and parent therapy. I was the primary therapist in this case on out-[2]patient and in-patient status.

Through these meetings I became increasingly aware of the problems that Joey and his parents had. I became

aware that Joey was being held responsible for the verbalized problems within the home but, that these problems seemed primarily to belong to the mother and step-father. It was my opinion that Joey was being scape-goated by his parents for their difficulties. My impression was that Joey was neither psychotic nor hyperkinetic. I concluded that it was not really in Joey's best interest to be hospitalized but, that placement in another home environment might have best met his needs. In a different home environment, one of love and acceptance, I doubt that Joey would have experienced the problems attributed to him, and with which he had to deal.

The circumstances involved in Joey's adoption, at 8 hours old, I believe contributed to the situation that evolved in the eventual hospitalization of him. The adoptive mother and her first husband, Dr. Joe Lister, were invited to dinner at a home of a physician friend, with whom Dr. Lister arranged the adoption of this out-of-wedlock boy without his wife's awareness; the physician friend felt the marriage to be rather shaky and decided that, in order to survive, it needed a child.

The eventual divorce of the Lister's, and the adoptive mother's assuming total responsibility for the care and supervision of Joey, plus the unusual circumstances involved in the initial adoption (for which Mrs. Lister was prepared neither emotionally nor for the necessary items required in the care of an infant) I believe contributed to the basic negative feelings of this mother for this child, and contributed to the rejection of Joey exemplified by his admission to C.S.H. The mother's remarriage also contributed to her need to reject Joey and "start over again"; I did not feel that Mr. Shermer ever really wanted Joey in his new marriage.

From the time of Joey's admission and until I left the C & A Unit, in March 1971, nothing occurred during his course of hospitalization that led me to alter my impression that hospitalization was not in his best interest. During this period of time I felt that an adoptive home, rather than a foster home, would best meet his needs. Some permanency was needed that adoption could provide.

At the time of the decision to admit Joey to the C & A Unit, made by Dr. Portuondo, Unit Director, I was not consulted as to my recommendation regarding his need for hospitalization.

My contact with Jimmy Ramey, prior to my departure from the C & A Unit in March 1971, was quite minimal. I was aware that the reason for his admission, as shared with me, was that Stephens County DF & CS had run out of foster homes and felt they had no other alternative than hospitalization. At this time my reaction was that such a reason for hospitalization was indeed unusual if not inappropriate.

18 Nov. 1975 — /s/ JANET SCOTT
Date — JANET SCOTT

/s/ CAROLYN R. BLOODWORTH
Notary Public, Baldwin County, Ga.
My Commission Expires: 1-6-78.

(SEAL)

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

REVISED STATEMENT OF FACTS

Plaintiff J.L. was adopted when he was 8 hours old. Following the adoption, the adoptive parents experienced marital difficulties, stress, and eventually, the marriage failed.

In June, 1969, when J.L. was 5 years old, J.L.'s adoptive mother remarried. Family tension continued, J.L. had problems in school [See Exhibit #2-B-1; Summary Progress Note: 6/75], and in March, 1970, J.L.'s adoptive mother and stepfather contacted Central State Hospital regarding out-patient services. After less than 8 weeks of out-patient services which consisted of weekly sessions of both individual therapy for J.L. and parent therapy [See P-1; Affidavit of Janet Scott, Social Worker], J.L. was "voluntarily" admitted by his adoptive mother and stepfather to Central State Hospital on May 18, 1970.

The diagnosis given at the time of admission was "Hyperkinetic reaction of childhood; predisposition: poor home environment." [See Exhibit #1-I]. However, admission notes written by Dr. Zapatera (now Gutierrez) state: "I wonder if he was hyperkinetic . . . he does not look like that now?" [See also Exhibit #1-G-1 and 2].

For J.L., at 6 years of age, the familial situation was unstable; there was a traumatic point and he related to this with a good deal of frustration, irritability, hyperactivity, the school couldn't handle him, the family

[2]

couldn't handle him, and no one wanted him. It is not unusual to see hyperactive [2] reaction in children exposed to a traumatic situation. [See p. 18 of transcript of testimony of Dr. Wayne Hodges].

In November of that year, J.L. was given a form notice of his right to discharge as a voluntary patient. He signed the receipt of that notice when he had just turned 7 years of age. [See Exhibit #3]

J.L. was confined in Central State Hospital from May 18, 1970, through September 18, 1972, when he was released on furlough to his adoptive mother and stepfather. Within 10 days he was returned to the institution by them. It was reported that: "the furlough did not work out because of the stress of the family situation and the inability of the school to effectively discipline J.L.." [See Exhibit #2-B-1; Summary Progress Note: 6/75]. He has been continuously confined in the hospital since that date.

Following the birth of her own child to her second marriage, J.L.'s adoptive mother joined with his adoptive father in April, 1974, in attempting to voluntarily relinquish their parental rights to Central State Hospital. [See Exhibit #4]. J.L. has seen neither his adoptive parents nor his stepfather since that date.

As early as 1973, over two years ago, hospital personnel recommended specialized foster care for J.L. [See p. 7 of transcript of testimony of Dr. Gutierrez]. That recommendation was continually reaffirmed and documented in hospital records: "Continued hospitalization would not provide the emotional climate necessary to meet J.L.'s needs. Recommendation: J.L. be considered for foster home placement with continued out-patient therapy." [See Exhibit #5-A-2; Psychological Evaluation:

[2]

6/75]. "Foster care would be most beneficial . . . he is obviously suffering from some degree of institutionalization and should experience success in a loving, concerned relationship as soon as possible." [See Exhibit #2-B-4 and 5; Summary Progress Note: 6/75].

[3]

Specialized foster care remains the recommendation of the psychologist and psychiatrist on J.L.'s ward at the present time. [See p. 7 of transcript of testimony of Dr. Gutierrez; p. 17 of transcript of testimony of Dr. Hodges].

PLAINTIFF J.R.

In November, 1962, at the age of 3 months, J.R. was declared a deprived child and removed from the home of his natural parents. He has had no contact with his natural parents since that time. Stephens County Department of Family and Children Services was given temporary custody of J.R. at that time, and eventually secured permanent custody "for the purpose of placing said child for adoption." [See Exhibit #8].

J.R.'s life for the next seven years consisted of 2 hospital visits and placement in 5 foster homes. In his first foster home, J.R.'s foster parent was a widow who, in addition to J.R., took care of another infant, and 3 younger children. It was felt that "he suffered a lack of stimulation and attention" in that environment, and was subsequently placed, after hospitalization for medical problems, in two other foster homes. J.R.'s positive adjustment to his fourth foster home was cut short due to the illness of that foster mother and the financial inability of the fourth set of foster parents to care for J.R. J.R.'s fifth foster placement was also successful initially, however, when he started acting out, those foster parents, in

their early 60's, decided they could not handle this seven year-old boy. [See Exhibit #9-A-1 and 2; Summary for Placement Resource].

On May 26, 1970, Dr. John Curtis, Psychiatric consultant at Stephens County Mental Health Clinic where J.R. had been receiving services for approximately one year stated: "I feel it would be of benefit to him . . . to stay in the foster home—for an additional year since he has been in seven different foster homes and this must be very upsetting to him, and if he has to [4] move, it will be even more upsetting." [See Exhibit #9-B-8; Stephens County Mental Health Clinic Records].

Nevertheless, on June 26, 1970, J.R. was "voluntarily" admitted to Central State Hospital by his guardian, Stephens County Department of Family and Children Services.

He was diagnosed as having Borderline Mental Retardation and Unsocialized Agressive Reaction of Childhood. [See Exhibit #7-C; Admission Summary]; however, screening at that time indicated he was not retarded. [See Exhibit #7-I; Interoffice Correspondence]. No answer was given on the Personal History admission form as to what aspect of the patient's behavior made hospitalization necessary [See Exhibit #7-F-3; Personal History]. It was noted that "this boy has been at seven years of age in six different foster homes. We feel that that is a traumatic experience." [See Exhibit #7-H-3; Psychiatric Examination].

The admitting physician concluded that hospitalization was appropriate because J.R. "would benefit from the structured environment and would be enrolled in school activities and would enjoy living and playing with boys of the same age." [See also Exhibit #7-H-3].

[4]

Recommendations for foster home placement were made in early 1973 [See p. 10 of transcript of testimony of Dr. Gutierrez] [See also Exhibit #9-A-2 and 4; Summary for Placement Resource: 6/73]: "Central State Hospital has for some months been requesting long term foster care or (an) adoptive home . . . it is felt that (J.R.) will now only regress if he does not get a suitable home placement as soon as possible . . . (he) has received maximum benefits from Central State's program."

This recommendation was subsequently reaffirmed and documented in the hospital records: "efforts to obtain a foster placement should be primary at this time lest J.R. become a permanently institutionalized child." [See Exhibit #10-A-2; Psychological Evaluation: 8/73]. "Foster care is recommended." [See Exhibit #10-C; Restaffing: 11/74].

[5]

At present, J.R.'s psychologist indicates: that J.R. "is just a mildly retarded individual who needs structure and supervision but could function much better in a setting characterized by . . . a lot less structure . . . continued

hospitalization would be harmful for J.R." [See pp. 12-13 of transcript testimony of Dr. Wayne Hodges].

Respectfully submitted,

/s/ DAVID GOREN

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[1]

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

STIPULATION OF FACTS FOR THREE-JUDGE HEARING

Plaintiffs J.L. and J.R. and the class of children they represent, through their attorneys, and Defendants T.M. (Jim) Parham, W. Douglas Skelton, M.D., and W. T. Smith, M.D., through their attorneys, stipulate to the following facts for the purpose of this civil action:

1.

Plaintiff J. L. was admitted to Central Georgia Regional Hospital (formerly Central State Hospital) on May 18, 1970, upon application by his adoptive mother and stepfather pursuant to Ga. Code § 88-503.1. He was six (6) years old at the date of his admission. See Exhibit #1.

2.

J.L. has normal intelligence and at the time of his admission to the hospital was diagnosed as having hyperkinetic reaction and adjustment reaction to childhood. He had previously received some treatment as an outpatient for approximately two months prior to the date of his admission. The admitting physician determined that hospitalization was appropriate because J.L. could "not function outside the hospital and admission might be helpful." See Exhibit #2.

[2]

3.

J.L. was admitted in accordance with Ga. Code § 88-503.1 and thus prior to his admission, there was no

[2]

formal or informal administrative or judicial hearing statutorily required or held. He was therefore not given notice, counsel, the opportunity to present evidence, to subpoena witnesses and documents, confront and cross examine witnesses, and expert examination and assistance by an expert not employed by the Department of Human Resources and other procedural safeguards associated with an administrative or judicial hearing in order to determine his need for hospitalization.

4.

J.L. was confined in Central Georgia Regional Hospital from May 18, 1970, through September 18, 1972, when he was released on furlough. Within ten (10) days he was returned to the institution by his adoptive mother and stepfather. It was reported that the furlough did not work out because of the stress of the family situation and the inability of the school to effectively discipline J.L. He has been continuously confined in the hospital since that date. See Exhibit #2.

5.

On November 4, 1970, J.L. was given written notice of his right to discharge. That notice informed him that his discharge may be conditioned upon the consent of his parents. He signed his receipt of that notice when he was seven years old. A copy of that notice is attached as Exhibit #3.

6.

In April, 1974, J.L.'s adoptive parents attempted to voluntarily relinquish their parental rights to the hospital. J.L. has not seen his adoptive parents since that date. See Exhibit #4.

[3] 7.

J.L. would testify that he does not wish to be confined in a State Mental Hospital.

8.

The opinion of Central Georgia Regional Hospital personnel with regard to J.L.'s need for hospitalization is found in Exhibits #2 and 5 attached hereto.

9.

On October 31, 1975, the Department of Family and Children Services of Baldwin County petitioned the Juvenile Court of that county for temporary custody of J.L. On that same day, Judge George Jackson granted the Department of Family and Children Services of Baldwin County temporary custody of J.L. See Exhibit #6.

10.

J.L. has not been placed in a specialized foster home. A specialized foster home is defined by the defendants to mean a home in which the foster parents are enabled by training and experience to provide care for children who have been diagnosed as having severe physical, mental or emotional handicaps and who would benefit from the intensive care provided by such foster parents. A one hundred twenty-five ($125.00) dollars a month service fee is paid to each specialized foster home in addition to the per diem rate for each child. There is a limit of two children for each specialized foster home. Medical or psychiatric treatment for children in specialized foster homes is paid for by the state or county in addition to the per diem rate and service fee.

11. [4]

Plaintiff J.R. was committed to Central Georgia Regional Hospital on June 26, 1970 upon application of his Guardian, Stephens County Department of Family and Children Services pursuant to Ga. Code § 88-503.1. He was seven years old at admission. See Exhibit #7.

12.

Upon admission, J.R. was diagnosed by one report as not being mentally retarded and another report as being borderline mentally retarded. He was also diagnosed as having "aggressive reaction of childhood." The admitting physician determined that hospitalization was appropriate because J.R. would "benefit from the structured environment and would be enrolled in school activities and would enjoy living and playing with boys of the same age." See Exhibit #7.

13.

J.R. had been placed in the custody of the Stephens County Department of Family and Children Services after the Juvenile Court of that County declared him to be a deprived child and removed him from the home of his natural parents. J.R. has not had contact with his natural parents since removal from their home. See Exhibit #8.

14.

J.R. has had five foster home placements prior to admission. He received some treatment as an out-patient at the Stephens County Mental Health Clinic from May 22, 1969 until his admission to the hospital. See Exhibit #9.

15.

J.R. was admitted in accordance with Ga. Code § 88-503.1 and thus prior to his admission, there was no

formal or informal administrative or judicial hearing statutorily required [5] or held. He was therefore not given notice, counsel, the opportunity to present evidence, to subpoena witnesses and documents, confront and cross examine witnesses, and expert examination and assistance by an expert not employed by the Department of Human Resources and other procedural safeguards associated with an administrative or judicial hearing in order to determine his need for hospitalization.

16.

J.R. has had no contact outside the hospital for the last five years except for approximately four temporary holiday visits to foster homes.

17.

J.R. is presently hospitalized in Central Georgia Regional Hospital and would testify that he does not wish to remain there. The opinion of Central Georgia Regional Hospital personnel with regard to J.R.'s need for hospitalization is found in Exhibit #10 attached hereto.

18.

J.R. has not been placed in a foster home or an adoptive home.

19.

A portion of the class of children represented by plaintiffs were admitted to regional mental health hospitals in accordance with Ga. Code § 88-503.1, and thus, prior to their admission, there was no formal or informal administrative or judicial hearing statutorily required or held. They were therefore not given notice, counsel, the opportunity to present evidence, to subpoena witnesses and documents, confront and cross examine witnesses, and

expert examination and assistance by an expert not employed by the Department of Human Resources and other procedural safeguards associated with an [6] administrative or judicial hearing in order to determine his need for hospitalization.

20.

Juveniles are confined in state mental health facilities as voluntary patients pursuant to § 88-503.1 who would testify that they are being confined against their will.

21.

The general admission procedures to Central State Hospital for juveniles admitted by their parents or guardian pursuant to Ga. Code § 88-503.1 is as follows:

(a) Parents or guardians bring their child to the admissions unit in the Powell Bldg.

(b) Psychology personnel screen the child for evidence of mental retardation.

(c) If there is evidence of mental retardation, the child is then screened by the mental retardation unit for admission to that unit.

(d) If the child is not mentally retarded, he is then screened by psychiatric unit admitting physician.

(e) If the physician finds the child to be appropriate for admission, the parent or guardian then signs voluntary admission papers and the child is admitted into the facility.

22.

Admission of a child to a private residential psychiatric treatment facility is made upon application of a parent and upon the determination of the admitting physician that the child is suitable for residential treatment and not

following a formal or informal judicial or administrative hearing.

[7]

23.

There is no state-wide statute, regulation or policy establishing the frequency of periodic reviews for children committed to state mental hospitals pursuant to Ga. Code § 88-503.1. The superintendent determines policies regarding periodic review of cases by staff personnel within each regional mental health hospital.

24.

There is no judge, hearing officer or evaluator not employed by the Department of Human Resources who conducts periodic reviews in any state mental health facility with respect to juveniles admitted in accordance with Ga. Code § 88-503.1.

25.

The numbered exhibits referred to above and attached hereto are incorporated herein by this reference and made a part of this stipulation.

Agreed and stipulated to this _____ day of November, 1975.

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Senior Assistant Attorney General

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Assistant Attorney General

Attorneys for Defendants

EXHIBIT # 1

A. Inter-Office Correspondence from J. T. Harris

B. Admission Summary

C. Application for Voluntary Admission

D. Notice to Voluntary Patient

E. Representation Form

F. Personal History and Treatment

G. Admission Note

H. Admission Record

I. Diagnosis

MILLEDGEVILLE STATE HOSPITAL

Georgia Department of Public Health

INTER-OFFICE CORRESPONDENCE

TO: ALL ADMISSION EMPLOYEES DATE 5-15-70

FROM: J. T. Harris

SUBJECT: Joey Lister

Joey Lister is to be admitted to this hospital on May 18, 1970 from Baldwin County. He is to be sent directly to the Children's Unit 1 South.

JTH:ldl

Exhibit #1-A

ADMISSION SUMMARY

Name of Hospital: CENTRAL STATE HOSPITAL

Name (Last)	(First)	(Middle)	(Maiden)	Patient Number
LISTER,	Joey	Mack		172,897

Date of Admission	Type Admission	Type Commitment	Unit/Ward	Modality
5-18-70	First	[illegible]-Voluntary	08-Children's Unit 1S	In-Patient

Address (Street No. and Name)	(City)	(County)	(State and Zip Code)	How long at Present Address	Telephone
Premier Mobile Park	Mill[illegible]ville	Baldwin Co., Ga.		Unk	452-30

Race and Sex	Age	Birth Date	Birthplace (City, County, State)	U. S. Citizen
White Male	6	10-1-196[illegible]	Tift Co., Ga.	Yes

Nearest Relative (Name)	Relationship	Address	Telephone
Carrie R. Shermer	Mother	Premier Mobile Park, Milledgeville	452-3

Person Having Legal Custody or Guardianship	Address	Telephone No.	Child Live
NA			

Person To Notify in Emergency	Relationship	Addresses (Home and Work)	Telephone
Dr. and Mrs. Wilbur Baugh	None	Gordon Rd., Milledgeville, Ga.	452-2

Patients Representatives (Name)	(Street No. and Name)	(City, State and Zip Code)
1st Carrie R. Shermer	Premier Mobile Park	Milledgeville, Ga.
2nd Kenneth Lee Shermer	Premier Mobile Park	Milledgeville, Ga.

Martial Status	Number of Children	Education (No. of Years)	Employed or Retired	How long employed	Patient's Occupation	Spouse's Occ
Single	NA	First Grade	NA	NA	NA	NA

Name and Address of Employer (Patient)	Name and Address of Employer (Spouse)
NA	NA

Last Day Patient Worked	Patient	Annual Income Family	Social Security Number	Receives S.S. Benefit	Health Insurance Number
NA	none	$9,000	None	No	NA

Veteran	Car Serial Number	Receives Military Benefits (including VA)	Receives Welfare Benefits	Receives Child Benefits
No	NA	No	No	No

Hospital Insurance	Policy No.	Group No.	Insurance Company (Name and Address)
Yes			Prudential Ins. Co.

Religious Preference	Name and Address of Church
Baptist	Unk

Father's Name	Birthplace	Living	Age	S. S. Number	Veteran	Religious Preference
Joe Lister	Unk	Yes				

Mother's Name	Birthplace	Living	Age	S. S. Number	Veteran	Religious Preference
Carrie R. Shermer	Tift Co.	Yes				

Family Physician (Name and Address): Dr. James Baugh, Milledgeville, Ga.

Related Treatment (Name and Address): None

IP	OP	Dates (Month - Day - Year) From	To

Referral Source (Name and Address): Dr. James Baugh, Milledgeville, Ga.

Admitting Clerk: JBB — Time Adm.: 2:00 p

Admitting Diagnoses (Mental and Physical): Emotionally disturbed.

Final Diagnoses: Hyperkinetic Reaction of Childhood #308.0

No. Days	Movement Date	Unit	Mode
2 yrs			
3 mos			
20 days	9-8-72	Chil 1S	Imp

Type Separation: Furloughed — Disposition: Parents

Condition: Improved — Prognosis: Poor

Cause of Death — Autopsy

Date Discharged: 9-8-72 — Physician's Signature: [illegible]

MH 100 (Revised 2-70)

Exhibit #1-3

Admission Summary

GEORGIA DEPARTMENT OF PUBLIC HEALTH
APPLICATION FOR VOLUNTARY ADMISSION TO
Central State HOSPITAL

(By Authority of Section 88-503.1, Georgia Health Code, Ga. Laws, 1969, pp. 5050645)

I, JOEY MACK LISTER (Type or Print Full Name), Age 6

residing at PREMIER MOBILE HOME PARK-EATONTON ROAD (Street Address)

MILLEDGEVILLE (City) GEORGIA (State)

BALDWIN (County) request admission to CENTRAL STATE Hospital on a voluntary basis and hereby agree to abide by the rules of the Hospital (see back of page) and to leave the Hospital willingly when informed by the medical staff that I no longer need to stay.

Joey Lister by K.L. Shermer — Signature

Witness: J.B.B. Atchison

Title: Clerk IV

Address: CSH

NOTE: Parent or guardian must sign below if applicant is under 18 years of age, or under 14 years of age if admission to an Evaluating Facility is desired, or by Guardian if applicant has been adjudged legally incompetent.

As parent or guardian of the above named individual I agree to all of the provisions of this application.

Carrie R. Shermer — Signature of Parent/Guardian

MAY 18, 1970 — Date

Witness: Josephine Rogdale

Title: Notary Public

Address: 1324 Simmons Road, Milledgeville, Ga.

☐ Family History record Included ☐ To Follow by Mail

EXHIBIT 1-C

MH 1000 [Section 88-503.1] Georgia Department of Public Health

BEST COPY AVAILABLE

NOTICE TO VOLUNTARY PATIENT OF RIGHTS TO DISCHARGE

(By Authority of Section 88 503.4, Georgia Health Code, Ga. Laws 1969, pp. 506-545)

To: (Voluntary Patient) Joey Mack Lister

Hospital Central State

Date 5-18-70

Please be advised that you, your legal guardian, parent, spouse, attorney, or adult next-of-kin may request your discharge in writing at any time after five days following your admission to this hospital, excluding Saturdays, Sundays, and legal holidays, subject to the following provisions:

1) If you have been admitted on your own application and a request for your discharge is made by a person other than yourself, your discharge may be conditioned upon your agreement thereto.

2) If you have been admitted prior to your 18th birthday on the application of your parent or guardian, your discharge prior to becoming 18 years of age may be conditioned upon the consent thereto of such parent or guardian.

3) If you have been admitted as an adjudged incompetent on the application of your guardian, your discharge prior to a legal restoration of competency may be conditioned upon the consent thereto of your guardian.*

Within 5 days, excluding Saturdays, Sundays, and legal hospital, after receipt of your written request for discharge by the Superintendent, you will be discharged, unless your attending physician finds that your discharge would be unsafe for you or others, in which case proceedings for your involuntary hospitalization will be initiated within the 5-day period as provided for by law.

Notwithstanding the above, you may also be discharged if, in the judgment of your attending physician or the Superintendent, such discharge would contribute to the most effective use of this hospital in the care and treatment of mentally ill persons, or if in their judgment, you no longer require hospital care.

James B Craig Superintendent

I hereby acknowledge receipt of this notice.

Date 5-18-70

x Joey Mack Lister Patient
by K L Shermer

cc First Representative
Second Representative
Clinical Record (receipted copy)

MH 1011 (Section 88 503.4) Georgia Department of Public Health

EXHIBIT #1-D-1

_____ Hospital

RULES AND REGULATIONS FOR VOLUNTARY ADMISSION TO _____ HOSPITAL

1. For voluntary admission, arrangements must be made with the Superintendent or his representative in advance of coming to the Hospital for confirmation of availability of beds. This may be done by telephone or in writing.

2. When admitted on a voluntary basis, a patient agrees to submit to all of the rules and regulations of the Hospital.

3. For a voluntary admission, a patient must have sufficient mental clarity to be responsible for and willingly sign the Application for Voluntary Admission.

4. For a voluntary admission, a patient must recognize the nature of his condition and the purpose for which he is admitted.

5. A patient will not be accepted on a voluntary basis when criminal charges or indictment are pending against said patient.

6. When admitted on a voluntary basis, a patient agrees for the doctors at the Hospital to administer any type of standard treatment deemed advisable.

7. A voluntary patient may request a discharge from the Hospital by addressing the Superintendent in writing in accordance with Section 88-503.3, Georgia Health Code, Ga. Laws, 1969, pp. 506-545.

NOTE: Any item in question which is not covered in the above rules and regulations may be directed to the Division of Mental Health, Georgia Department of Public Health, the hospital, your local health department or your local physician.

EXHIBIT #1-D-2

5-18-70
(DATE)

Joey Mack Lister
NAME

172,897
HOSPITAL NUMBER

Children's Unit I-S
WARD

1st REPRESENTATIVE: Carrie R. Shermer (Mother) 452 3053
NAME

Premier Mobile Park
STREET ADDRESS

Milledgeville Ga
CITY STATE

31061
ZIP CODE

2nd REPRESENTATIVE: Kenneth Lee Shermer (Step father) 452 3018
NAME

Premier Mobile Park
STREET ADDRESS

Milledgeville Ga
CITY STATE

31061
ZIP CODE

1. Patient's Legal Guardian
2. Spouse
3. An Adult Child
4. Parent
5. Attorney
6. Adult Next-of-kin
7. Adult Friend

EXHIBIT #1-E

PERSONAL HISTORY AND TREATMENT PERMIT
CENTRAL STATE HOSPITAL
MILLEDGEVILLE, GEORGIA

Please Answer All Questions

Patient's Name: Mr. Miss Mrs. LISTER (Last) JOEY (First) MACK (Middle and Maiden)

Hospital Case No. _____ (Supplied by hospital after admission) Date of Admission 5-18-70 County: BALDWIN

Age: 6 YEARS Race: CAUC. Date of Birth: OCTOBER 1, 1963 Social Security No. NONE

Place of Birth: TIFT COUNTY-GEORGIA How long a resident of Georgia: LIFE

Legally (court appointed) Guardian: CARRIE RUTLAND SHERMER - EATONTON ROAD-MILLEDGEVILLE, GA.
Name Address

Guardian of: Person _____ Property _____ Both X

Address of pt. prior to admission: PREMIER MOBILE PARK (Street) MILLEDGEVILLE (City) 31061 (Zip Code)

Give Name and Relationship of Other Adults in Household:
KENNETH LEE SHERMER — STEP-FATHER
Name — Relationship

Are there any drugs to which patient is allergic? (Name them) NONE KNOWN

If patient is presently taking any types of medication, please list: RITALIN

Patient is: Single [X] Married [ ] Widowed [ ] Divorced [ ] Separated [ ] How long _____

If the patient has been married before, give the following information for each marriage:

Spouse's Name	Address	Year married	Year separated or divorced	Reason

If the patient has children, give the indicated information for each:

Name	Address

With whom will patient live when he leaves hospital? MOTHER AND STEP-FATHER
Name and address: PREMIER MOBILE HOME PARK-EATONTON ROAD, MILLEDGEVILLE, GA.

What is the patient's principal occupation? N/A

Did the patient work regularly in the last year? _____ Average Monthly Income _____

EXHIBIT #1-F

ther persons or the patient himself, are working and have contributed to the patient's support, give following information

KENNETH LEE SHERMER	STEP-FATHER	ANNOUNCER(RADIO)	370.00
CARRIE R. SHERMER	MOTHER	COUNTY HOSPITAL	360.00
Name	Relationship	Principal Occupation	Avg. Monthly Income

as the patient receive income from any of these sources: (Underline)

ocial Security, Welfare, Veterans' Administration, Railroad Retirement? Amount NONE

f patient is 65 years of age or older, is he/she signed up for Medicare?

Part A (Hospital) Part B (Medical)

Hospital Insurance Co. (Medicare)

If any person close to the patient receives income from these sources and shares this income with the patient, indicate following:

Name Relationship Source Amount

Give highest school grade completed or degree received NONE

Give the following information on school attendance as indicated:

Age Entered 1ST Was Attendance Regular? YES Grades Good or Bad? POOR TO FAIR

Grades Repeated? NONE Age Left School? 6 Reason? UNCONTROLABLE

If the patient served in the Armed Services, give the following information:

Service Year entered Year left Type Discharge Service No. Service Occupation Claim No.

Is the patient active in church? Denomination? BAPTIST

If the patient was ever arrested, give the indicated information:

Date Place Reason Disposition

Give the following information regarding the patient's parents:

K.L. SHERMER	27	RADIO ANNOUNCER	HIGH SCHOOL
Father (STEP FATHER)	Age	Occupation	Education
CARRIE R. SHERMER	32	X-RAY TECHNICIAN	HIGH SCHOOL, COLLEGE&X-R
Mother	Age	Occupation	Education
JOE M. LISTER	35	DENTIST	UNKNOWN
Step-Parent	Age	Occupation	Education

If parent(s) is deceased, give the age at death and cause:

If the patient's parents ever obtained a divorce, give age of patient at the time 3 YEARS

Give the following information regarding siblings, (includes those who may have died or who may be half-siblings):

Name Age Address Occupation (if deceased, give cause)

EXHIBIT #1-F-2

patient has been mentally ill before give the following information:

ox. Dates of Illness Physician or Hospital where treated & address

as the patient ever used alcohol excessively? Drugs?

If any relative of the patient has been mentally ill, addicted to alcohol or drugs or been in a mental hospital, give the following information:

NONE

Name Relationship Nature of Illness Hospital, if hospitalized

Briefly, what about the patient's behavior makes you feel he needs hospitalization? EXTREMELY AGGRESSIVE, HAS NO REGARD FOR AUTHORITY.

Did this behavior appear suddenly or gradually? PRESENT FROM EARLY AGE

Check any of the following which describes the patient's behavior. Felt someone or something had special control over him, ___ Had fears of being harmed, ___ Heard imaginary voices, ___ Smelled peculiar odors, ___ Saw imaginary persons or things, ___ Thought they were someone else, ___ Experienced loss of memory, ___ Seemed to lose interest in people and things: X Neglected appearance; ___ Spoke angrily to others, X Was physically violent to self or others, X Depressed, X

If the patient has been suicidal, homocidal, violent, or destructive, describe:

Describe any serious illnesses, injuries or operations as indicated:

Illness, injury or operation Date Physician or Hospital where treated and address

If any close relative of the patient or the patient himself has had any of the following illnesses, give the information requested below: Heart Disease, Asthma, Ulcers, Diabetes, Tuberculosis, Epilepsy or Fits, Syphilis, Cancer, Huntington's Chorea, Wilson's Disease, Pick's Disease:

Name Relationship Describe Illness

Has the patient ever had convulsions, fits, blackouts, or epilepsy?

Were these light or severe? How often did they occur?

Name, Address & Relationship of informant:

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY: DR. AND MRS. WILBUR BAUGH (Name)

JORDON ROAD-MILLEDGEVILLE (Address) 31061 (Zip Code) 452-2453 (Telephone No.)

EXHIBIT #1-F-3

AUTHORIZATION AND TREATMENT PERMIT

Date 5-18-70

I, the nearest relative or guardian, hereby authorize the Superintendent or any Central State Hospital staff member whom he might designate to:

1. Employ any recognized psychiatric treatment, including electro-convulsive therapy, and to perform any and all operations, procedures or treatment that may be necessary or advisable for the benefit and improvement of the patient.

2. Release to other hospitals, physicians, social agencies or other professionally qualified agencies or persons any information which they may desire that is recorded in the medical and psychiatric record of the patient when such would contribute to the treatment of the patient.

3. Arrange for public transportation home for the patient in the event that no responsible relative can come for him when he is ready for release from the hospital.

4. Permit patient to wear and use such personal items as: clothing, jewelry, false teeth, spectacles and I, the nearest relative or guardian, agree to assume full responsibility for the loss and destruction of such articles.

Joey Linton by
Signature of Patient
K L Themen
Witness

Carrie L. Themen
Signature of Nearest relative or guardian

CSH-645 Dec 1968

EXHIBIT #1-F-4

CENTRAL STATE HOSPITAL

ADMISSION NOTE

PRESENTING PROBLEM: This about 6'½ y.o. w/male was brought to the Emerg by his stepfather for gen extreme aggressiveness and no regard for authority as reasons for bringing him to the Hospital, this behavior has been growing worse lately. He has been violent and at times he has looked depressed.

IMPRESSION: The boy is attractive and cooperative, asked for his father but came in my office and sat down. He answered some questions about who was he living & and he had no brothers, two sisters on he started saying "I don't know" I noticed he was with the sign of tears, warden his hands and making circles on the floor & his feet. Asked for a toy, gave a puzzle he could do it in 2 minutes. Then I took him to the dayroom where he was introduced to the other boys.

REMARKS: The boy has been on Ritalin 5 mg bid & Mellaril 50 mg hs

ADMISSION DATE: 5/18/70	ADMISSION TYPE: 54
SIGNATURE: Ofapaterson	DATE: 5/18/70
DATE OF BIRTH	MARITAL STATUS

LISTER, JOEY MACK
W. 127 WH 54 10-1-1963
5-18-70 555
[redacted] LOG 1 SOUTH

CSH-414 ADMISSION NOTES

EXHIBIT #1-G-1

BEST COPY AVAILABLE

Dr. Sparks said Tk. short time Strength [illegible] 2/18/70
Dr. Sparks said Tk. short time Strength [illegible]
called and it was known if test and only
depressed. 2/18/70 2K
Patient is his no comment epithe.
cried - is necessary for Tentative diagnosis,
Impression of child's Room.

Gaba Tarun

MEDICAL RECORD
DESKS
RECEIVED
MAY 22 1970

EXHIBIT #1-G-2

ADMISSION RECORD

DATE 5-18-70

DESCRIPTION: AGE 6 HEIGHT 4'2¾" WEIGHT 53lb. TEMP 98.6 PULSE 88 B/P 84/50 RESP 22

ATTITUDE TOWARD ADMISSION: FEAR ____; WILLING ✓ COMBATIVE ____; WITHOUT UNDERSTANDING OF WHAT IS HAPPENING ____;

PHYSICAL: AMBULATORY ✓; WHEEL CHAIR ____; STRETCHER ____; CRUTCHES ____;
GAIT: STAGGERING ____; ODOR OF ALCOHOL ____; ODOR OF PARALDEHYDE ____; BLIND ____;
PUPILS UNUSUALLY ENLARGED ____; OR UNUSUALLY SMALL ____; COLOR OF EYES ____;

CLOTHING: WELL ARRANGED ✓; DISARRANGED ____; CLEAN ✓; SOILED ____;

SKIN: UNUSUALLY PALE ____; FLUSHED ____; UNUSUALLY MOIST ____; UNUSUALLY DRY ____;
CLEAN ✓; SOILED ____; WAS PATIENT GIVEN A BATH? ✓; TYPE Shower; SCARS None (Chart);
SCRATCHES ____; BRUISES ____ (Chart); SCABES ____; PEDICULI PUBIS ____; CUTS ____;
BURNS ____; ERUPTIONS ____; DECUBITUS ____;

HAIR: WELL-GROOMED ✓; DISARRANGED ____; MATTED ____; COLOR OF HAIR Blonde CLEAN Yes;
SOILED ____; EVIDENCE OF PEDICULI ____; HEAD TREATED FOR PEDICULI ____;

ORIENTATION: CAN GIVE NAME Yes; KNOWS WHERE HE IS Yes; KNOWS APPROX. DATE No;

PERSONAL POSSESSIONS: JEWELRY ____; MONEY ____; VALUABLE PAPERS ____; DESCRIBE THESE THREE ITEMS ON BACK OF SHEET: GLASSES ____; TYPE ____; DENTURES ____;
FULL OR PARTIAL ____; BRIDGE ____; DOES PATIENT HAVE PERMISSION TO USE PERSONAL BELONGINGS Yes

MENTAL STATE: DOES NOT ANSWER QUESTIONS ____; DOES NOT SEEM TO UNDERSTAND QUESTIONS ____;
TALKS VERY LITTLE ____; OVERTALKATIVE ____; IS TALK MEANINGFUL Yes;

EMOTIONS: UNWARRANTED FEAR ____; EXPRESSIONS OF HATE ____; TOWARD WHOM ____; IDEAS OF PERSECUTION ____; BY WHOM ____;

IDEAS: STRANGE EXPRESSED THOUGHTS (explain) ____

COMPLAINTS: (any expressions of physical or mental nature) ____

SPECIMEN COLLECTED: URINE Yes; FECES Yes

LUGGAGE: 1 Ivory C. Suitcase
(Add any pertinent information on back of sheet.)

TRANSFERRED: ____

PATIENT RECEIVED BY: Hilma Carlson
SIGNATURE

CHECKED BY: Wilma Gadson
Irma B. Cummings
SIGNATURE

SIGNATURE:	DATE:

CSH-82 ADMISSION RECORD EXHIBIT #1-

LISTER, JOEY MACK
172,897 WM 54 10-1-1963
5-18-70 005

CHILDREN'S BLDG 1 SOUTH

CENTRAL STATE HOSPITAL

DIAGNOSIS

THIS PATIENT WAS PRESENTED TO THE STAFF AND WAS GIVEN A DIAGNOSIS OF:

DIAGNOSIS: Hyperkinetic Reaction of Childhood, # 308.0

PREDISPOSITION: Poor home environment

STRESS: Unknown

IMPAIRMENT: Moderate

PROGNOSIS: Fair to guarded

TREATMENT: Hospitalization, Chemotherapy, Milieu Therapy, Special School, and Individual Psychotherapy

TYPE OF ADMISSION
VOLUNTARY -- 54

SIGNATURE
212 DATE 6-30-70

CSH-612 DIAGNOSIS

LISTER, JOEY JACK
172,897 WM 54 [illegible]
5-18-70 005

CHILDREN'S BLDG. 1 [illegible]

EXHIBIT #1-I

EXHIBIT #2

A. Admission Summary

B. Summary Progress Note - 6/75

C. Final Summary

EXHIBIT #2-A

Admission Summary

ADMISSION SUMMARY

[illegible] STATE HOSPITAL: 800-172-897

[illegible] JOEY MACK 254-96-0360

9-18-72 (Rec.) First (17) Children's Unit (1) S. In-Patient:

Premier Mobile Park Milledgeville Baldwin GEorgia unk. 452-308

White Male 6 10-1-[illegible] Tift County, Georgia: yes:

Carrie R. Sharmer Mother: [illegible] Milledgeville 452-308

N/A

Dr. & Mrs. Wilbur Baugh Face: Gordon Rd., Milledgeville, Georgia 452-245

1st Carrie R. Sharmer ~~Premier Mobile Park~~ Milledgeville, Ga.

2nd Kenneth Lee Sharmer ~~Premier Mobile Park~~ Milledgeville, Ga.

Single: N/A First Grade N/A N/A N/A N/A

N/A

None:

No:

Yes:

Prudential Insurance Company:

Baptist: Unknown:

Joe Lister unknown: yes:

Tift Co. Yes:

[illegible] Milledgeville, Georgia:

K.T. [illegible], Box (502), Milledgeville, (Step-Father) JMC 8:50 A.

EMOTIONALLY DISTURBED:

HYPERKINETIC REACTION OF CHILDHOOD: 308.00

EXHIBIT #2-A-1

EXHIBIT #2-B

Summary Progress Note - 6/75

SUMMARY PROGRESS NOTE June 1975

RE: Joey Mack Lister
CASE NO.: 172,897
Children's Building
Admission from Baldwin County, 9-12-72
Birthdate: 10-1-[illegible]3

Custody pending to in July, 1975
Mrs. Ann Etheridge
Baldwin County DFCS
Milledgeville, Georgia

Joey was readmitted to this facility September 18, 1972, after a two week furlough. He had been here for two years being admitted for the first time May 18, 1970, and was placed on furlough September 8, 1972. He was to live at home but attend the School of Special Education here. This arrangement did not work out due to the stress of the family situation and the inability of the school to effectively discipline Joey. Before his furlough if he became disruptive in school, he could be returned to the ward. As an out patient, this could not be done. At that point he could not have functioned in a public school.

He [illegible] adoptive son [illegible] Mrs. Carole Lister [illegible] [illegible] 8 hours old.

Following the adoption the Lister marriage failed. There were some stormy, unhappy times for the whole family. Mrs. Lister was granted custody of Joey and there was never a meaningful relationship established with the father before or after the divorce.

Mrs. Lister married Mr. Ken Shermer in June, 1969, and she states he helped Joey for a while. When Joey entered Northern School [illegible] [illegible] classroom behavior [illegible] disruptive [illegible]

in March, 1970.

Mr. Shermer states as a baby he was hyperactive and destructive, getting worse as he got older. He could get into more things. He was unable to finish anything or sit still and watch T.V. The reasons for Joey's admission were hyperactivity, uncontrollable, disruptive behavior and unable to adjust to school. He was also destructive.

Shortly after admission, the family tried to cooperate with family therapy. Mr. Shermer even though apparently movitated at first became discouraged with Joey's cyclic behavior and no consistent improvement. Mrs. Shermer was threatened by the process of really changing the situation. She felt a lot of guilt about Joey's condition.

She really cared for Joey and it was a painful, traumatic decision to give him up. It is to her credit that she dealt with the feelings of helplessness and hopelessness Joey created for her in the hope he could be put in a successful foster home. Her own marriage was threatened by Joey's disruptive behavior in the home and this was the only course [illegible] her own natural child's welfare. Both she and Dr. Lister relinquished [illegible]

Since Joey's 5 years here he has improved some only to revert to his usual disruptive, demanding behavior. He has been tried on Ritalin, Amphetamine Sulfate 5 mg., and various tranquilizers with no consistent improvement. At present he is on Navane 5 mg. bid p.o. He is an insecure child who feels he must have your attention by his endless request. The older he gets and the more hopeless he feels, he has begun to be physically [illegible] both to the staff and to the other children.

He has some medical problems in allergies [illegible]

EXHIBIT #2-B-2

respiratory symptoms. Restriction from milk has helped some. He has had frequent treatment with Penicillin for his allergies. He is also prone to skin lesions, minor areas becoming infected and dry skin. When he is under stress his allergies and skin problem is more evident. He was seen in Hemotology Clinic from June, 1973, to January, 1974, for generalized ecchymasis and petechrael rash on his body. It was felt this could have been drug induced from Keflex, an antibotic that he had to take for an infected sutured arm. He does bruise very easily, from the slightest trauma he will turn bluish green. The hematology work up showed Idiopothic Thrombocytopenic Micraytic, Mildly hypochronic anemia. From time to time Joey has to receive a course of treatment with feasal due to a low grade anemia. He was treated successfully with Prednisolone and dismissed from hematology clinic January 30, 1975. Chest x-rays and EEG's have been within normal limits. The examination of his eyes and hearing [illegible]

Joey has adjusted fairly well to the fact he has to go in foster [illegible] place to go. He has been on a few visits. While these visits [illegible] no major problems, none of the homes have invited him back. A continuing home for visitor foster care would be the most therapeutic thing that could happen for Joey.

His ward behavior still swings from a nice well behaved child to one who is demanding and nothing could satisfy. He has a low frustration tolerance [illegible] on both the children and staff when thwarted. He [illegible] with the therapy [illegible] more appropriate behavior. He relates well [illegible]

EXHIBIT #2-B-4

Bel[illegible] County DFCS will have a hearing regarding [illegible] in July. Hopefully they will be able to provide resources [illegible] for foster care, which as stated earlier would be the most beneficial step in Joey's interest.

He is going to the Learning Center 1/2 day, four days a week and doing well. His school problems are more behavioral than academic.

Joey would need a specialized foster home or certainly parents who could ride out the storm while he is adjusting. Since he finds it hard to believe he won't be rejected, a warm, supported, truly involved couple will be a neccessity.

Joey has run away on several occassions recently. He states he is so unhappy and would rather be any place than here. This running away behavior started after the complete deterioration of the home and I feel this is a bid for attention to his unhappy circumstances.

Even though Joey has functioned under a behavior modification system [illegible] years, [illegible] doesn't fully understand and accept the consequences of his [illegible] granted, he feels it's because he is [illegible]. [illegible] often for the difficulty he has and quite often he is in trobble more often than the other children on the ward.

Joey received an IQ of 90 on Form L-M of the Stanford-Binet on 5-25-70 and a score of 88 on the same test April 19, 1972. His achievement scores showed him to be functioning about two years behind his chronological grade level but he has shown improvement since admission. He appears [illegible] self punitive child. He is unable [illegible] [illegible] his foster parents without a lot of [illegible] [illegible] suffering from some degree of inst[illegible]

and should experience success in a loving concerned relationship as soon as possible.

Joey is an attractive child who, once reassured of your interest, can be a nice child to be around.

Bettie Joyce Harris R.N.
Bettie Joyce Harris, R.N.
Team Leader, 1 South

O. Gutierrez M.D.
Odilia Z. Gutierrez, M.D.
Director, C & A Unit

EXHIBIT #2-B-5

EXHIBIT #2-C

Final Summary

CENTRAL STATE HOSPITAL

FINAL SUMMARY

ADMISSION DATE: 5-16-70 DATE OF RELEASE: 9-8-72

DIAGNOSIS AND CODE NO: Hyperkinetic reaction of childhood. #308.0

SUMMARY OF TREATMENT: Individual psychotherapy, chemotherapy, recreational, and music therapy. Laboratory tests and chest x-rays reported normal. Patient has had lymphadenities due to small infections of the skin and also urticaria received adequate treatment at Outpatient Clinic. EEG normal.

HOSPITAL COURSE: Patient was admitted because of his disruptive behavior at home and at school too, short attention span and hyperactivity; he was on Ritalin. Patient did not show improvement during the first months in the building but later on he was more quiet and less restless and started going home in a "behavior modification" basis. It worked fairly well for a few weeks. Later on the policy was discontinued and Joey was going home, sometimes he would stay and sometimes they would bring him back before he was supposed to. During all this time, family therapy has been performed and finally [illegible]

RECOMMENDATION OR DISPOSITION: Keep Joey in special education, get in touch with therapist for help and guidance.

DICTATED BY: Odilia Zapatero, M.D. 101

TYPE OF ADMISSION: Voluntary

[illegible] 9-11-72

[illegible] SUMMARY

LISTER, JOEY [illegible]
800 - 172,897 [illegible] 10-1-63
5-15-70 [illegible]

EXHIBIT #2-C-1

EXHIBIT # 3

Notice to Voluntary Patient of Rights to Discharge

CENTRAL STATE HOSPITAL

NOTICE TO VOLUNTARY PATIENT OF RIGHTS TO DISCHARGE

(By authority of Section 88-503.4, Georgia Health Code, Ga. Laws 1969, pp. 505-48.)

TO (Voluntary Patient) Date November 4, 1970

Joey Mack Lister

CSH # 172,897

Please be advised that you, your legal guardian, parent, spouse, attorney or adult next-of-kin may request your discharge in writing at any time after five (5) days following your admission to this Hospital, excluding Saturdays, Sundays, and legal holidays, subject to the following provisions:

1. If you have been admitted on your own application and a request is made by a person other than your self, your discharge may be conditioned upon your agreement thereto.

2. If you have been admitted prior to your 18th birthday on the application of your parent(s) or guardian, your discharge prior to becoming 18 years of age may be conditioned upon the consent thereto of such parent(s) or guardian.

3. If you have been admitted as an adjudged incompetent on the application of your guardian, your discharge prior to a legal restoration of competency may be conditioned upon the consent of your guardian.

Within five (5) days, excluding Saturdays, Sundays, and legal holidays, after receipt of your written request for discharge by the Superintendent, you will be discharged, unless your attending physician finds that your discharge would be unsafe for you or others, in which case proceedings for your involuntary hospitalization will be initiated within the five-day period as provided for by law.

Notwithstanding the above, you may also be discharged if, in the judgement of your attending physician [illegible]

(Superintendent)

I hereby acknowledge receipt of this notice.

Date _____

Joey Mack Lister

(Patient)

EXHIBIT #3

BEST COPY AVAILABLE

EXHIBIT #4

Relinquishment of Parental Rights

STATE OF GEORGIA

COUNTY OF BALDWIN

RELINQUISHMENT OF PARENTAL RIGHTS

We the undersigned, CLAUDE REBECCA RUTLAND LISTER SHEFFER and JOE M. LISTER, both of Baldwin County, Georgia, do hereby freely and voluntarily consent to the placement of our adopted son, to-wit, JOEY LISTER, by and through the CENTRAL STATE HOSPITAL, a state mental institution located in said Baldwin County, Georgia; and.

WE hereby surrender all of our joint and individual parental rights, including the right to his custody, and control, and any and all other rights we have or may have, either jointly or individually, under the laws of the State of Georgia, in said child, unto said Central State Hospital and the placement agency or persons thereby designated by said state mental institution.

WE expressly waive any and all other and further notice of placement, if any, of said child, service of notice of placement, including any conferences, meetings, or hearings on said matter and the time and place thereof are also hereby waived.

WE fully understand that we are unequivocably relinquishing any and all of our parental rights for the expressed purposes hereinbefore stated. This document is freely and voluntarily executed by each of us and we fully understand its purport.

This the 25th day of April, 1974.

Carrie Rebecca Rutland Lister Sherrer
CARRIE REBECCA RUTLAND LISTER SHERRER

Signed and sealed

in the presence of:

Brenda U. Snow

[illegible]
Notary Public, Baldwin County, Georgia

This the 30th day of April, 1974.

Joe M. Lister
JOE M. LISTER

Signed and sealed

in the presence of:

Mary R. McClary

My Commission expires 3/3/78
Notary Public, Baldwin County, Georgia

This is to certify that this is a true and correct copy of the original document.

Mary R. McClary N.P.
Baldwin County, Ga.
Commission expires 3/3/78

EXHIBIT #4-2

GILMORE, WADDELL & PHILLIPS
ATTORNEYS AT LAW
221 South Wilkinson Street
Milledgeville, Georgia 31061

EXHIBIT #5

A Psychological Evaluation

PSYCHOLOGICAL EVALUATION

NAME: Joey Lister
CASE NO.: 172897
AGE: 12
BIRTHDATE: 10/1/63
COUNTY: Baldwin

WARD: Children's 1 South
REFERRED BY: Dr. Gutierrez
ADMISSION DATE: 5/18/70; 9/18/72
EXAMINATION DATE: 7/8/75
DATE OF REPORT: 7/9/75

BACKGROUND: Joey Lister has been a patient in the Children's Building for a period of approximately five years. He has been a severe behavior problem during most of his stay. Joey's behavior appears to be somewhat cylical with periods of relatively appropriate behavior interspersed with severe acting out which manifests itself in aggression and hostility toward others. On September 8, 1972, Joey was furloughed to his foster mother. Shortly after his furlough, Joey became a discipline problem in school, and he was apparently unable to adjust to the home situation. Joey was re-admitted on September 18, 1972. Joey has an extensive history, and further medical, psychological, and social reports are available in the ward chart.

INTERVIEW DATA: Joey expressed considerable anxiety about his relationship with his parents. He stated, "I know their names, but I don't want to know them. I don't talk about them anymore." When asked about his father, Joey said, "I never seen my real father." He then hid his head and began to cry. Joey feels that his natural parents "gave him away." Judging by his attitude and behavior, Joey has considerable repressed anger and emotional pain concerning his relationship to his parents. Joey also refused to discuss his relationship with his foster parents although he did indicate that he felt rejected by them.

Joey's main concern during the interview was his hope of leaving the Children's Building for foster home placement. Joey stated that he believed he could behave if he were placed outside the hospital. He is fearful that this placement may not occur and avoids thinking about it.

BEHAVIORAL OBSERVATIONS: Joey came to the testing and interview sessions neatly dressed and displayed good personal hygiene. He was very active during the testing session, grabbing test materials, and walking around the room inspecting various objects and books on the shelves. Joey eventually settled down after some coaxing, and he was generally cooperative with the examiner. He was negativistic at times during the testing. Joey was easily frustrated by tasks which he felt were too difficult or [illegible] low frustration [illegible] testing. [illegible] or other symptoms associated with psychosis.

TESTS ADMINISTERED: Wechsler Intelligence Scale for Children - Revised (WISC-R), Bender Gestalt Test, Sentence Completion, Draw-A-Person (D-A-P), Blacky Picture Series.

TEST RESULTS: On the WISC-R, Joey achieved a Verbal IQ of 72, a Performance IQ of 101, and a Full Scale IQ of 84. The Full Scale IQ places him in the Dull normal range of intelligence. Joey seemed to be easily frustrated on this test and gave up on tasks that he felt were too difficult for him. Joey preferred the performance subtests and generally would not put forth the same effort with verbal tasks. His verbal score may be somewhat below his actual capability because of his low frustration tolerance; however, the examiner feels that he is handicapped by a lack of verbal skills such as associative thinking, verbal comprehension, and the utilization of abstract concepts in solving problems. His low vocabulary score suggests that his quality of language and richness of ideas is below average. His intellectual strengths seem to be his perceptual sensitivity, attention to detail, and concentration. Joey is alert to [illegible] cues in his environment and he has the capacity for appropriate responses to social situations. He also exhibits at least average ability for perceptual analysis and synthesis, with adequate nonverbal concept formation.

EXHIBIT #5-A-1

Psychomotor testing indicated that Joey's visual-motor maturation is age appropriate. There was no suggestion of central nervous system dysfunction.

Personality testing revealed that Joey has deep feelings of inadequacy, probably resulting from the insecurity and emotional deprivation of his childhood. Joey has many infantile needs which were not met in his childhood. These needs are still very much with him and require restitution. Joey has a very pessimistic outlook of his world although outwardly he tries to maintain an appearance of hope and optimism.

Joey expresses strong unresolved conflicts concerning his relationship to his parents which he attempts to blot out of consciousness. These are extremely painful areas of thought and feeling that he is fearful of confronting. There are some developed fantasies about "killing mother or dad" which is a way of attempting to deal with his anger and hurt. One of the important goals of therapy with Joey would be to establish a therapeutic relationship to assist Joey in expressing some of these repressed feelings of anger and hostility.

SUMMARY AND RECOMMENDATIONS: Joey is an insecure, emotionally starved child who is experiencing deep feelings of inadequacy and hopelessness. He has repressed some very powerful feelings of rejection and hostility. Joey needs a warm secure relationship with adult parent figures who will be able to cope, at first, with his excessive demands for their attention and affection. His fear of being rejected again is extremely strong and it will require time and patience before his excessive demands will subside. He is in need of continued psychotherapy to assist him in ventilating his repressed feelings and to help provide some stability. Continued hospitalization would not provide the emotional climate necessary to meet Joey's needs. It is my recommendation that Joey be considered for foster home placement with continued outpatient therapy. Potential foster parents should be counselled and clearly informed concerning Joey's needs and specific problems.

Ryan Lincoln, Psychologist
Children and Adolescents Unit

Marilyn Edmistion, Ph.D.
Clinical Director, Psychology
Children and Adolescents Unit

cc: Ward Chart, File.

EXHIBIT #5-A-2

EXHIBIT #6

A. Juvenile Court Petition - Baldwin Department of Family and Children Services

B. Report Accompanying Petition

C. Juvenile Court Order Granting Temporary Custody to Department of Family and Children Services

Joe Mack Lister Jr.

The Petitioner, Mrs. [illegible], respectfully [illegible] the following facts:

[illegible] forth in the caption. [illegible] Lister Jr., [illegible] parents. [illegible] Central State Hospital [illegible]

EXHIBIT #C-A-1

temper tantrums and de[illegible] child [illegible] to function in the public sch[illegible] system [illegible] to [illegible] as a [illegible] to function [illegible] setting, said [illegible] whose children had [illegible] by this child. [illegible] with Central State [illegible] approximately three years trying to learn to deal with said child and his [illegible] his behavior at Central [illegible] he would be sent [illegible] mother and Mr. [illegible] mother [illegible] personnel [illegible] the child. [illegible] another living arrangement [illegible] appropriate [illegible] for this child. [illegible] 1974. [illegible] contact [illegible] time.

[illegible] child's adoptive parents, were divorced [illegible], when said child was three years of age, said adoptive [illegible] has had no contact with said child for the past several [illegible] contributed [illegible] to this child. [illegible] support [illegible]

EXHIBIT #G-A-2

BEST COPY AVAILABLE

[illegible] custody of said child [illegible] Mack Lister Jr. be placed [illegible] Department of [illegible] and Children Services. [illegible] that said parent be ordered to pay an appropriate [illegible] amount of child support [illegible] said child.

Petitioner [illegible] hereto requesting [illegible] with according to law.

[illegible]

Subscribed and sworn to before me

on information and belief

this [illegible]

[illegible]

Notary Public, [illegible]

EXHIBIT #G-A-3

Baldwin County Department
of Family and Children Services
By: Anne A. Etheridge Caseworker II
November 10, 1975

Lister, Joe Mack Jr.
Child in Central State Hospital
Children's Building

CIRCUMSTANCES INVOLVING REFERRAL OF CHILD TO AGENCY

In November of 1973, Our Agency was contacted by Carolyn Grant, social worker in the children's building at Central State Hospital concerning the above named child. After giving some background on the child's situation she stated that Mrs. Sherner wanted to relinquish custody of Joey to our agency and requested that I talk with Mrs. Sherner about this possibility. In early November I talked with Mrs. Sherner and we discussed the different ways that custody is relinquished to our agency. Mrs. Sherner stated that she had been working toward her decision of relinquishing custody of Joey for approximately a year and a half.

In January of 1974, I discussed with Mrs. Sherner the process that our state office would require for us to take custody of this child. Mrs. Sherner and her ex-husband, Dr. Lister, were requested to petition the court to have custody of Joey given to our Agency. We agreed to take temporary custody of this child and requested that a support clause be included in the court order. In May of 1974, we received a copy of a document signed by Mrs. Sherner and Dr. Lister, attempting to relinquish custody to Central State Hospital. This paper was notarized by a notary public, but did not have the signature of a Judge. Colonel Schuyler, legal advisor to Central State Hospital, stated that Central State Hospital could not take custody of a child as they are not a child placing agency.

Since this incident in the spring of 1974, we have been in contact with Mrs. Sherner's lawyer and have tried to make it clear that we were

requesting that the parents of the child petition the court to give us temporary custody.

On October 30, 1975, Judge Owens of the Federal Court ordered that a petition be presented to the Juvenile Court of Baldwin County by 5:00 P.M. on October 31 or he would sign a statement placing custody of Joey with our Agency. Our legal advise was that this action by the Federal Court Judge would only complicate matters of custody further, so a petition and an order giving us temporary custody of Joey was presented to Judge Jackson and signed by him on October 31, 1975.

BACKGROUND AND CURRENT STATUS

Joey was adopted as a young infant by Mrs. Carrie Lister Sherner and Dr. Joe Mack Lister Sr. The marriage of his adoptive parents was a turbulent one and ended in divorce in 1966. It was in the divorce decree that Joey would live with his mother, but Dr. Lister was ordered to pay child support and was allowed visiting privileges. This decision was handed down in the Superior Court of Tift County. Although Dr. Lister has not supported and has fulfilled no parental responsibilities towards this child, this order has remained unchanged. The rights of neither parent have been terminated and at the present time there are two legal parents involved with Joey's custody; his mother, Mrs. Sherner, and his adoptive father, Dr. Lister.

Joey was admitted to Central State Hospital in May of 1973, by his mother. He had become too much of a problem for his mother to manage at home. Joey was having problems in school and also within the neighborhood. At the time of his admission his behavior was described as "extremely agressive with no regard for authority". One of Joey's

teachers described him as a "very hyperactive child who over-reacts to all situations." Joey's mother had remarried one year before Joey was admitted to Central State Hospital. The step-father, Jon Sherner, seemed to be patient and understanding with the child's problems and showed great concern for this child. At one point Mr. Sherner talked of adopting Joey. Mr. and Mrs. Sherner worked closely with Central State Hospital attempting to understand Joey's behaviour and to learn ways and methods of dealing with the behavior so that Joey could live at home. They took him home for the week-end visits, for vacations and so forth, but his behavior did not seem to be improving. According to Mrs. Sherner, she and her husband arrived at the decision with Central State Hospital that Joey would never be able to function in their home in 1972. However she stated that it took her about a year, and a half to make a definite decision about relinquishing custody of Joey. It was not until the time when this decision was made that our Agency became involved in this case.

In 1973, when we became concerned with the custody question of this child, we were also requested by Central State Hospital, specifically Carolyn Grant, social worker and Betty Harris, R.N. (Joey's primary therapist) to find another living arrangement for Joey. We discussed, on many different occasions, what type of foster parents or institution would be able to cope with Joey. A report dated August 1973, was sent to us. This report stated that Joey was going into his fourth year of hospitalisation at Central State Hospital and "he continues to be a severe behavior problem." It was also noted that Joey's attitude towards himself tends to be rather punitive and that his self-confidence is very low. It was agreed that if a very special family could be found who would be willing to try to cope

with these problems that Joey might possibly succeed in a foster home placement. However this family was going to have to be a very "special" one, as it was recognized that Joey would need an extreme amount of attention and care. Foster families and children who are nearer "normal" are very hard to find and foster parents who are willing to even try to cope with a child such as Joey are almost impossible to locate. Our Agency was also concerned that Joey may had so many failures with his family life. We felt that we should be very careful before another placement with Joey was made as he would see the failure of a foster care placement as another rejection and failure for him personally. Our department cannot pay for institutional foster care unless a child is an AFDC child and then it can pay only under certain circumstances. Joey is not an AFDC child.

RECOMMENDATIONS

Our Agency is willing to accept temporary custody of Joey but because of the financial situation we would need child support to help us arrange for the specialized care that this child needs.

Our Agency will seek a specialized home for Joey outside our area as we do not have a suitable home in this area. Even though we realize that this child may not be able to function outside Central State Hospital, we are willing to try to see if a placement will work for him. If another institution is available or recommended we would be willing to make the appropriate referral and attempts to get him into such an institution. However, again we will emphasize that financial support will be needed for us to do this.

GEORGIA, BALDWIN COUNTY

IN THE SUPERIOR COURT OF SAID COUNTY AS A JUVENILE COURT

The above petition having been read and considered by this court, the court has determined that the filing of this petition is in the best interest of this child and the public:

IT IS, THEREUPON, ORDERED that each of the above named partied be and appear before this court at The Courthouse Milledgeville, Ga on the 12th day of November, 1975 at 10:00 o'clock, AM then and there to show cause why the child named in said petition shall not be dealt with in accordance with the provision of law in such case. It is further ordered that temporary custody of said child be placed with the Baldwin County Department of Family and Children Services until the above hearing date. It is also ordered that a true and correct copy of the petition and process be served upon the parents, guardian, or other person having custody, control, and supervision of said child named in the petition.

This 31st day of October 1975.

George T Jackson
Judge Baldwin Superior
Court acting as Judge
of Juvenile Court

The above hearing has been continued because of lack of service on Joe Mack Lister SR. It is further ordered that temporary custody of said child be continue in the Baldwin County Department of Family and Children Services until further order of this Court.
This 12th Day of Nov. 1975 George T Jackson
Judge

EXHIBIT #7

EXHIBIT #7

A. Admission Record

B. Inter Office Correspondence from J. T. Harris

C. Admission Summary

D. Application for Voluntary Admission

E. Representation Form

F. Personal History and Treatment Permit

G. History of Mental Illness

H. Psychiatric Examination

I. Inter Office Correspondence Re: M.R.

J. Admission Note

K. Diagnosis

ADMISSION RECORD

DATE _____

DESCRIPTION: AGE [illegible] HEIGHT [illegible] WEIGHT [illegible] TEMP [illegible] PULSE [illegible] B/P [illegible] RESP [illegible]

ATTITUDE TOWARD ADMISSION: FEAR ____; WILLING [illegible] COMBATIVE ____ WITHOUT UNDERSTANDING OF WHAT IS HAPPENING ____;

PHYSICAL: AMBULATORY [illegible] WHEEL CHAIR [illegible] STRETCHER ____ CRUTCHES [illegible];
GAIT: STAGGERING ____ ODOR OF ALCOHOL [illegible] ODOR OF PARALDEHYDE ____ BLIND ____;
PUPILS UNUSUALLY ENLARGED ____ OR UNUSUALLY SMALL ____ COLOR OF EYES [illegible];

CLOTHING: WELL ARRANGED ____; DISARRANGED ____ CLEAN [illegible] SOILED ____.

SKIN: UNUSUALLY PALE ____ FLUSHED ____ UNUSUALLY MOIST ____; UNUSUALLY DRY ____;
CLEAN ____ SOILED ____; WAS PATIENT GIVEN A BATH? ____; TYPE ____ SCARS [illegible] (Chart);
SCRATCHES ____; BRUISES ____ (Chart); SCABES ____; PEDICULI PUBIS ____ CUTS [illegible];
BURNS ____; ERUPTIONS ____ DECUBITUS ____;

HAIR: WELL-GROOMED [illegible]; DISARRANGED ____; MATTED ____; COLOR OF HAIR Red; CLEAN [illegible];
SOILED ____ EVIDENCE OF PEDICULI ____; HEAD TREATED FOR PEDICULI ____.

ORIENTATION: CAN GIVE NAME [illegible] KNOWS WHERE SHE IS [illegible] KNOWS APPROX. DATE [illegible].

PERSONAL POSSESSIONS: JEWELRY [illegible] MONEY ____ VALUABLE PAPERS ____; DESCRIBE THESE THREE ITEMS ON BACK OF SHEET. GLASSES ____ TYPE ____ DENTURES ____;
FULL OR PARTIAL ____ BRIDGE ____; DOES PATIENT HAVE PERMISSION TO USE PERSONAL BELONGINGS [illegible]

MENTAL STATE: DOES NOT ANSWER QUESTIONS [illegible]; DOES NOT SEEM TO UNDERSTAND QUESTIONS ____;
TALKS VERY LITTLE [illegible]; OVERTALKATIVE ____; IS TALK MEANINGFUL ____;

EMOTIONS: UNWARRANTED FEAR ____; EXPRESSIONS OF HATE ____; TOWARD WHOM ____; IDEAS OF PERSECUTION ____; BY WHOM ____.

IDEAS: STRANGE EXPRESSED THOUGHTS (explain) ____

COMPLAINTS: (any expressions of physical or mental nature) ____

[illegible]

LUGGAGE ____
(Add any pertinent information on back of sheet.)

TRANSFERRED: ____

PATIENT RECEIVED BY: [illegible] CHECKED BY: [illegible]

[illegible] SIGNATURE

Mrs Lillie L. Kennedy SIGNATURE

RAMEY, JAMES LAMAR
173617 WM 54 8-14-62
6-25-70 127

[illegible]

SIGNATURE: DATE:

[illegible] ADMISSION RECORD

EXHIBIT #7-A

CENTRAL STATE HOSPITAL
Georgia Department of Public Health
INTER-OFFICE CORRESPONDENCE

TO: ALL ADMISSION EMPLOYEES DATE 6-24-70

FROM: J. T. Harris

SUBJECT: James Lamar Raney

James Lamar Raney, AGE: 7, Stephens County is to be admitted to this hospital soon. Requested by Colonel Schuyler. He is emotionally disturbed.

JTH:ldl

EXHIBIT #7-B

ADMISSION SUMMARY

Name of Hospital: CENTRAL STATE HOSPITAL

173,417

(Last)	(First)	(Middle)	(Maiden)	Street Address
RAMEY,	James	Lamar		?

Date of Admission	Type Admission	Type Commitment	Unit Ward	Mobility
6-25-70	1st	54-Vol	Children's Unit 1 S	In-Patient

Address (Street No. and Name)	(City)	(County)	(State and Zip Code)	Present Address	Telephone No.
Department of Family & Children Services, Toccoa, Stephens, Ga.				?	?

Race and Sex	Age	Birth Date	Birthplace (City, County, State)	U.S. Citizen
White Male	7	8-14-62	Stephens County, Ga.	Yes

Nearest Relative (Name)	Relationship	Address	Telephone No.
?	?	?	?

Person Having Legal Custody or Guardianship	Address	Telephone No.	Child Lives Wi
?	?	?	?

Person To Notify in Emergency	Relationship	Addresses (Home and Work)	Telephone No.
Barbara C. Carpenter Cild Welfare Counselor	None	Dept. of F&CS, Toccoa, Ga.	?

Patients Representatives (Name)	(Street No. and Name)	City, State and Zip Code	(Relationship)	(Telephone No.)
Barbara C. Carpenter	Department of F & CS	Toccoa, Ga.	Counselor	?

2nd

Marital Status	Number of Children	Education (No. of Years)	Employed or Retired	How long employed	Patient's Occupation	Spouse's Occupa
Single	0	1	N/A	N/A	Student	N/A

Name and Address of Employer (Patient)	Name and Address of Employer (Spouse)
N/A	N/A

Last Day Patient Worked	Annual Income: Patient	Annual Income: Family	Receives Social Security Benefits	Health Insurance Number
N/A	None	?	No	?

Veteran	C or Serial Number	Receives Military Benefits (Including VA)	Receives Welfare Benefits	Receives Child Benefits
No	N/A	N/A	Yes	?

Hospital Insurance	Policy No.	Group No.	Insurance Company (Name and Address)
No	N/A	N/A	N/A

Religious Preference	Name and Address of Church
Protestant	?

Father's Name	Birthplace	Living	Age	S.S. Number	Veteran	Religious Preference
Joe Ramey	?	Yes	47	?	?	?

Mother's Name	Birthplace	Living	Age	S.S. Number	Veteran	Religious Preference
Emogene Ramey	?	Yes	41	?	?	?

Family Physician (Name and Address)

2

Referral Source (Name and Address): Stephens County Department of Family & Children Services

Admitting Clerk: JMC

Time Admitted: 2:30 P.M.

Admitting Diagnosis (Mental and Physical): Emotionally disturbed.

Final Diagnosis:

1. Borderline mental retardation 310.90
2. Unsocialized, Aggressive reaction of childhood 30[illegible].10

No. Days	Movement: Date	Unit	Modality

Type Separation: Disposition

Prognosis

EXHIBIT #7-C

GEORGIA DEPARTMENT OF PUBLIC HEALTH
APPLICATION FOR VOLUNTARY ADMISSION TO
Central State HOSPITAL

(By Authority of Section 88-503.1, Georgia Health Code, Ga. Laws, 1969, pp. 5050-545)

James Lamar Ramey, Age 7
(Type or Print Full Name)

residing at in custody of State Department of Family & Children Services,
(Street Address)

Supervision by Stephens County Department of Family & Children Services,
(City) (State) Toccoa, Georgia

(County) request admission to Central State Hospital on a voluntary basis and hereby agree to abide by the rules of the Hospital (see back of page) and to leave the Hospital willingly when informed by the medical staff that I no longer need to stay.

Signature

Witness

Title

Address

NOTE: Parent or guardian must sign below if applicant is under 18 years of age, or under 14 years of age if admission to an Evaluating Facility is desired, or by Guardian if applicant has been adjudged legally incompetent.

As parent or guardian of the above named individual I agree to all of the provisions of this application.

Barbara C. Carpenter, Child Welfare Cas
Signature of Parent/Guardian

June 24, 1970
Date

Witness Gladelle M. Whitaker

Title Director

Address [illegible]

STEPHENS COUNTY DEPARTMENT OF FAMILY AND CHILDREN SERVICES
TOCCOA, GEORGIA

Gladelle M. Whitaker, Notary Public, State of Georgia. My Commission Expires June 10, 1972

☒ Family History record included

☐ To Follow by Mail

EXHIBIT #7-D-1

MN [illegible] Section 88-503.1 [illegible] Department of Public Health

_____ Hosptial

RULES AND REGULATIONS FOR VOLUNTARY ADMISSION TO _____ HOSPITAL

1. For voluntary admission, arrangements must be made with the Superintendent or his representative in advance of coming to the Hospital for confirmation of availability of beds. This may be done by telephone or in writing.

2. When admitted on a voluntary basis, a patient agrees to submit to all of the rules and regulations of the Hospital.

3. For a voluntary admission, a patient must have sufficient mental clarity to be responsible for and willingly sign the Application for Voluntary Admission.

4. For a voluntary admission, a patient must recognize the nature of his condition and the purpose for which he is admitted.

5. A patient will not be accepted on a voluntary basis when criminal charges or indictment are pending against said patient.

6. When admitted on a voluntary basis, a patient agrees for the doctors at the Hospital to administer any type of standard treatment deemed advisable.

7. A voluntary patient may request a discharge from the Hospital by addressing the Superintendent in writing in accordance with Section 88-503.3, Georgia Health Code, Ga. Laws, 1969, pp. 506-545.

NOTE: Any item in question which is not covered in the above rules and regulations may be directed to the Division of Mental Health, Georgia Department of Public Health, the hospital, your local health department or your local physician.

EXHIBIT #7-D-2

June 25, 1970
(DATE)

James Lamar Raney
NAME

173617
HOSPITAL NUMBER

C Fl 1 South
WARD

[illegible] patient [illegible] family - He is a ward of DFCS and they are the only ones to be notified - we were not able to get a history due to the

1st REPRESENTATIVE: Barbara C. Carpenter
NAME

Child Welfare Counselor
STREET ADDRESS

Dept of Family and Children
CITY STATE

Lenwise - Toccoa, Ga.
ZIP CODE

Please check phone book for correct number → phone 806-

2nd REPRESENTATIVE: _____
NAME

_____
STREET ADDRESS

_____
CITY

_____
ZIP CODE

1. Patient's Legal Guardian
2. Spouse
3. An Adult Child
4. Parent
5. Attorney
6. Adult Next-of-kin
7. Adult Friend

EXHIBIT #7-E

PERSONAL HISTORY AND TREATMENT PERMIT
CENTRAL STATE HOSPITAL
MILLEDGEVILLE, GEORGIA

Please Answer All Questions

Patient's Name Mr. ~~Miss~~ ~~Mrs.~~ Ramey, James Lamar
Last First Middle and Maiden

Hospital Case No. 173617 Date of Admission: 6-25-70 County: Stephens
(Supplied by hospital after admission)

Age 7 Race W Date of Birth: 8-14-62 Social Security No.

Place of Birth: Stephens Co. How long a resident of Georgia: Life

Legally (court appointed) Guardian: Name Address

Guardian of Person Property Both

Address of pt. prior to admission: Stephens Co. DF+CS Toccoa, Ga. 3057
Street City Zip Code

Give Name and Relationship of Other Adults in Household:
Herschel Satterfield (Foster Father)
Name Relationship

Are there any drugs to which patient is allergic? (Name them)

If patient is presently taking any types of medication, please list: Dilantin

Patient is Single ✓ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ How long

If the patient has been married before, give the following information for each marriage:

Name age address

With whom will patient live when he leaves hospital?
Barbara C. Carpenter, Social Work DF+CS.
Name and address

What is the patient's principal occupation? Student

Did the patient work regularly in the last year? None Average Monthly Income

EXHIBIT #7-F-1

Other persons or the patient himself, are working and have contributed to the patient's support, give following information:
State & County Funds

Name Relationship Principal Occupation Avg. Monthly Income

Does the patient receive income from any of these sources: (Underline)

Social Security, Welfare, Veterans' Administration, Railroad Retirement? Amount unknown

If patient is 65 years of age or older, is he/she signed up for Medicare?

Part A (Hospital) Part B (Medical)

Hospital Insurance Co. (Medicare)

If any person close to the patient receives income from these sources and shares this income with the patient, indicate following:

Name Relationship Source Amount

Give highest school grade completed or degree received: Special Education

Give the following information on school attendance as indicated:

Age Entered 7 Was Attendance Regular? yes Grades Good or Bad? Satisfactory

Grades Repeated? Age Left School? Reason?

If the patient served in the Armed Services, give the following information:

Service Year entered Year left Type Discharge Service No. Service Occupation Claim No.

Is the patient active in church? Denomination? Protestant

If the patient was ever arrested, give the indicated information:

Date Place Reason Disposition

Give the following information regarding the patient's parents:

Father Age Occupation Education

Emogene Ramey 41 unknown
Mother Age Occupation Education

Patient Permanently removed from family
Step-Parent Age Occupation Education

If parent(s) is deceased, give the age at death and cause

If the patient's parents ever obtained a divorce, give age of patient at the time

Give the following information regarding siblings, (includes those who may have died or who may be half-siblings):

Name Age Address Occupation (if deceased, give cause)

[illegible] brothers + sisters adopted by DF+CS

EXHIBIT #7-E-2

...the patient has been mentally ill before give the following information

Approx Dates of Illness — Physician or Hospital where treated & address

Has the patient ever used alcohol excessively? No Drugs? No

If any relative of the patient has been mentally ill, addicted to alcohol or drugs or been in a mental hospital, give the following information

Mother + father addicted to alcohol

Name — Relationship — Nature of Illness — Hospital, if hospitalized

Briefly, what about the patient's behavior makes you feel he needs hospitalization?

Did his behavior appear suddenly or gradually?

Check any of the following which describes the patient's behavior. Felt someone or something had special control over him, ___ Had fears of being harmed, ___ Heard imaginary voices, ___ Smelled peculiar odors, ___ Saw imaginary persons or things, ___ Thought they were someone else, ___ Experienced loss of memory, ___ Seemed to lose interest in people and things, ___ Neglected appearance, ___ Spoke angrily to others, ___ Was physically violent to self or others, ___ Depressed, ___.

If the patient has been suicidal, homicidal, violent, or destructive, describe:

Describe ... operations or operations as indicated

Illness, injury or operation — Date — Physician or Hospital where treated and address

... patient ... of the following illnesses, give the information requested below: Heart Disease, Asthma, Ulcers, Diabetes, Tuberculosis, Epilepsy or Fits, Syphilis, Cancer, Huntington's Chorea, Wilson's Disease, Pick's Disease

Patient — Epilepsy

Name — Relationship — Describe Illness

One Aunt — Heart Condition

Two Uncles — Mentally retarded

Has the patient ever had convulsions, fits, blackouts, or epilepsy? Unsure

Were these light or severe? Light How often did they occur? Infrequent

Name, Address & Relationship of Informant: Barbara C. Carpenter (Social Worker) Dept. of Welfare & Children Services, Eufaula, Ala. 3357

PLEASE ... IN CASE OF EMERGENCY:

Name

Address — Zip Code

Admission Services

Barbara C. Carpenter
Baptist Co. DFCS, Tuscaloosa, Ala.

AUTHORIZATION AND TREATMENT PERMIT

Date 6-25-70

I, the nearest relative or guardian, hereby authorize the Superintendent or any Central State Hospital staff member whom he may designate to

1. ... any recognized psychiatric treatment, including electro-convulsive therapy, and ... anesthetic and medical ... that may be ... physicians, nurses or agents of the ... consider ... whom they may desire that is recorded in the medical and psychiatric record of the patient, which such would contribute to the treatment of the patient.

3. Arrange for public transportation home for the patient in the event that no responsible relative can come for him when he is ready for release from the hospital.

4. Permit patient to wear and use such personal items as: clothing, jewelry, false teeth, spectacles and I, the nearest relative or guardian, agree to assume full responsibility for the loss and destruction of such articles.

X James Lonnie Ramey
Signature of Patient

Signature of Nearest relative or guardian

... Dec 1968

EXHIBIT #7-F-4

CENTRAL STATE HOSPITAL

HISTORY OF MENTAL ILLNESS

INSTRUCTIONS: INCLUDE (1) IDENTIFICATION, (2) INFORMANTS, (3) REASON FOR ADMISSION, (4) PRESENT MENTAL ILLNESS, (5) PAST HISTORY MENTAL ILLNESS, (6) PERSONAL HISTORY, (7) FAMILY HISTORY

IDENTIFICATION:

This is the first admission to Central State Hospital for this seven year old white male who was admitted on June 25, 1970. His birthdate is August 14, 1962. His occupation is that of student.

INFORMANTS:

Some material supplied by the Department of Family and Children Services of Toccoa, Georgia (Stephens County).

REASON FOR ADMISSION:

This patient has been destructive at home. His foster mother states that in May of 1970 he destroyed over one hundred canning jars during a fit of anger. He has "night attacks" and during these attacks he may run about the house apparently not fully conscious. During these attacks he has struck his head against the walls at times.

PAST HISTORY OF MENTAL ILLNESS:

James was with his mother only three months. When he was three months old he was removed from his home due to neglect and a court order was issued giving the custody of the patient to the Department of Family and Children Services of Toccoa, Georgia (Stephens

CONTINUED ON REVERSE SIDE

RAMEY, JAMES LAMAR
173,617 WM 5A 8-14-62
6-25-70 127
CHILDREN'S [illegible]

DATE
3-1-70

[illegible] HISTORY OF MENTAL ILLNESS

County). The patient was placed in foster care. Since this first placement he has had six different foster homes. Each time he seems to lose his place to a more favored child. Head banging began in his first foster home when he was eighteen months old and he was described as being very hard to manage. In October 1965 his temper tantrums were increasing and he was hospitalized on October 22, 1965 at Aidmore for an encephalogram and X-rays. All reports were negative. At that time he was screaming, spitting, and head-banging so much that he had to be sedated. He would not talk during his hospitalization. He has been in the last foster home since July 18, 1967 where, as mentioned above, he has been destructive and he had these so called "night attacks". For some time he was doing better but when he became a little fearful of his position in the family he revealed his jealousy, having temper tantrums and saying that "Mama was better to the girls than to me". Also, he started again wetting the bed. For one year James was the only child at home but lately one boy, fourteen years old, was placed at the foster home and he related well with this boy. Sometimes he was frustrated because the boy did not play with him all the time. This boy was moved on April 30, 1969 but on April 8, 1969, DeDe, age 8, and Terry, age 7, were placed in the foster home and James became jealous and fearful of his position in the family as mentioned above.

PERSONAL HISTORY:

[illegible] born to [illegible]

ounces. [illegible] came into foster care weighing eight pounds, four ounces, at three months of age. He sat alone at nine months and walked at about fourteen months of age. He began saying "Dada" and "Mama" at ten months of age. He continued in monosyllables until past his second birthday. He was weaned and toilet trained at two years of age. While in foster care he has had regular medical attention. Surgery for a right inguinal hernia was performed at Crippled Children's Clinic in October of 1964. James' health has been good. He has been treated for epilepsy but we feel that he has no epilepsy. His electro-[illegible] have been negative more than one time. Immunizations are current. All dental [illegible] encephalogram [illegible] at Central State [illegible]

EXHIBIT #7-G-2

CENTRAL STATE HOSPITAL

HISTORY OF MENTAL ILLNESS

INSTRUCTIONS: INCLUDE (1) IDENTIFICATION, (2) INFORMANTS, (3) REASON FOR ADMISSION, (4) PRESENT MENTAL ILLNESS, (5) PREVIOUS MENTAL ILLNESS, (6) PERSONAL HISTORY, (7) FAMILY HISTORY.

his physical examination was within normal limits, his chest X-ray was negative for T.B.

FAMILY HISTORY:

His father's present whereabouts are unknown. The father has a long record of crunkenness and conflicts with the law. The mother is living, her family has been recipients from the Department of Family and Children Services for many years. James has one sister and four brothers. Four of these children have been placed in foster homes. There is very good information about the family in the Summary of Life Experiences made by the Department of Family and Children Services. No history of T.B., asthma, diabetes, or epilepsy is in the family.

James was in school, doing quite well in the first grade class until the time his teacher retired and she was replaced in March by a much younger teacher. Then he became a disciplinary problem and created such a stir in the classroom that he disrupted activities. His pediatrician was consulted and James' dosage of Dilantin was increased in hopes of decreasing these destructive bursts of temper. The doctor also advised that

[illegible]

JH: mh

CONTINUED ON REVERSE SIDE

RAMEY, JAMES LAMAR
173,617 WM 54 8-14-62
6-25-70 127
[illegible]

[illegible] DATE: 8-11-70
[illegible] OF MENTAL ILLNESS

EXHIBIT #7-G-3

CENTRAL STATE HOSPITAL

PSYCHIATRIC EXAMINATION

INSTRUCTIONS: Include (1) Date, duration and circumstances of interview, (2) Patient's description, including appearance and activity, (3) Interpersonal attitudes, (4) Speech and communication, (5) Affect, (6) Ideation, (7) Perception, (8) Orientation and memory, (9) Intellectual function, (10) Judgement and insight, (11) Provisional diagnosis.

The three interviews we had with the patient were in the library of the Children's Building.

DESCRIPTION OF THE PATIENT:

The patient is a seven year old white male, an attractive red headed child. He was willing to go with the examiner to the library for an interview. He was neat and clean. His gait was normal. His psychomotor activity was normal or within normal limits for his age. No mannerisms were elicited.

INTERPERSONAL ATTITUDES:

He was cooperative with the examiner. His attention span for things which interested him appeared to be adequate. He was able to look at page after page of a book with many pictures about the trip to the moon done by the astronauts. He knows how old he is.

The patient is able to answer questions. His speech is logical. His form of thought is questionable.

RAMEY, JAMES LAMAR
173,617 WM 54 8-14-62
6-25-70 127
[illegible]

[illegible] DATE: 8-11-70
[illegible] PSYCHIATRIC EXAMINATION

EXHIBIT #7-H-1

AFFECT:

His affect was appropriate.

IDEATION:

The patient does not show any overt psychotic ideation at the present. Dr. Griffin examined this patient in October 1968 and he stated that this patient has a chronic anxiety concerning whether he will be cared for. He feels anger about this and acts this out with aggressive behavior. We agree with this statement.

PERCEPTION:

There is no history of hallucinations.

ORIENTATION:

The patient knows the day but he does not know the month or the year. He knows he is in Milledgeville. His memory appears to be good.

INTELLECTUAL FUNCTION:

The psychological evaluation done on this patient reports that he has an I.Q. of 77 [illegible] that he is capable of functioning in the dull-normal range of intelligence

PROVISIONAL DIAGNOSIS:

1. Borderline Mental Retardation, Code No. 310
2. Unsocialized, Aggressive Reaction of Childhood, Code No. 308.4

PREMORBID PERSONALITY:

Unknown.

EXHIBIT #7-H-2

CENTRAL STATE HOSPITAL

PSYCHIATRIC EXAMINATION

INSTRUCTIONS: Include (1) Date, duration and circumstances of interview, (2) Patient's description, including appearance a activity, (3) Interpersonal attitudes, (4) Speech and communication, (5) Affect, (6) Ideation, (7) Perception, (8) Orientation memory, (9) Intellectual function, (10) Judgement and insight, (11) Provisional diagnosis.

STRESSFUL FACTOR:

This boy has been, at seven years of age, in six different foster homes. He feel that this is a traumatic experience.

DEGREE OF IMPAIRMENT:

Mild.

RECOMMENDATIONS:

To keep the patient in the hospital. He will benefit from the structured environment. The patient whould be enrolled in school activities. He will enjoy living and playing with boys of the same age.

JR: mh

RAMEY, JAMES LAMAR
173,617 WM 54 8-14-62
6-25-70 12?
CHILDREN'S B[illegible]

DATE: 6-25-70

EXHIBIT #7-H-3

CENTRAL STATE HOSPITAL

Georgia Department of Public Health

INTER-OFFICE CORRESPONDENCE

TO: Admissions Office

DATE 6-2[illegible]-70

FROM: Dr. Robert W. Wildman, Chief Psychologist

SUBJECT: Screening of underaged patients

NAME: James Lamar Ramey

AGE: 7

IQ:

- [x] This individual is not retarded (IQ 70 or over)
- [ ] This individual is mentally retarded (IQ under 70)

COMMENTS:

[signature]

Psychology Technician

EXHIBIT #7-I

CENTRAL STATE HOSPITAL

ADMISSION NOTE

PRESENTING PROBLEM:

6/25/70 This is the first admission to CSH for this 7 y/o w/m student

Special education class 1st grade

IMPRESSION:

Pt have been in a foster home since he was 3 months old

Pt is very destructive, and can't tolerate any frustration

He was seen in the [illegible] Health clinic. Pt will be [illegible] his ongoing spell at night

REMARKS:

R/o Adjustment Reaction of Childhood

[signature] III

ADMISSION DATE:	ADMISSION TYPE:
SIGNATURE:	DATE:
DATE OF BIRTH:	MARITAL STATUS:

RAMEY, JAMES LAMAR
173617 WM 54 8-14-62
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CSH 414 ADMISSION NOTES

EXHIBIT #7-J

CENTRAL STATE HOSP TAL

DIAGNOSIS

THE PATIENT WAS PRESENTED TO THE WARD STAFF AND WAS GIVEN A DIAGNOSIS OF:

I agree with the diagnosis offered by Dr. [illegible] of:

DIAGNOSIS: 1. Borderline Mental Retardation, Code No. 31[illegible]
2. Unsocialized, Agressive Reaction of Childhood [illegible] 2[illegible].4

PREDISPOSITION: Unknown.

[illegible]: This boy has been, at seven years of age, in six [illegible] homes. We feel that this is a traumatic experience.

[illegible]: [illegible].

[illegible]: Fair.

[illegible]: To keep the patient in the hospital. We will [illegible] from the structured environment. The patient should [illegible] in school activities. We will enjoy living [illegible] with boys of the same age.

TYPE OF ADMISSION

DATE: 8-12-7

DIAGNOSIS

EXHIBIT #7-K

EXHIBIT #8

Court Order Giving Department of Family and Children Services Custody of J.R.

GEORGIA, STEPHENS COUNTY:

IN THE JUVENILE COURT IN AND FOR SAID COUNTY:

IN THE INTEREST OF JAMES LAMAR RAMEY, A WHITE CHILD, UNDER THE AGE OF SEVENTEEN YEARS:

JUVENILE COURT DOCKET NO: 211 - PAGE: 57

The above stated case coming on for a hearing on this date, all parties being present, after hearing the evidence the court finds from the evidence that the material allegations of fact set forth in the petition are true;

It is therefore ordered by the court that permanent custody of said child be and the same is hereby placed in the Georgia Department of Family and Children Services for the purpose of placing said child for adoption.

This the 27th day of October, 1966.

Judge of Superior Court, presidi as Judge of Juvenile Court in an for said County.

EXHIBIT #8

EXHIBIT #9

A. Summary for Placement Resource

B. Stephens County Mental Health Clinic Records

RAMEY, James Lamar, b. 08-14-62
127-2789
Stephens County Child

Worker: Becky H. Turner, CWS I
Stephens Co. Dept. of
Family & Children Services
Date: 06-12-73

Summary for Placement Resource

James Lamar Ramey is an attractive enough child, with an appeal about him and a genuine yearning for consistent, dependable love. In that, he is not so different from most children, but he is different from many in that he has never had really consistent love - never been able to develop any security or self-esteem. He is an average sized ten year old boy with a lean build. His brownish red hair is long enough to fall across his forehead. He has very fair, freckled skin, blue eyes, and fairly even teeth.

Jimmy has been at CSH since 06-25-70, after many foster home failures, following a very poor initial natural home and initial foster home experience, as an infant. In fact, Jimmy has reflected well, regrettably, what effect poor early maternal nurturance can have.

Our department became aware of Jimmy in November, 1962. The department was given temporary custody of Jimmy when he was three months old. He was removed from his natural family after it was discovered that he was badly malnourished. Later, Jimmy's other siblings were removed from the natural family and after the parents were unsuccessful in making any necessary improvements, following removal of the children, parental rights were terminated. Jimmy's five brothers and sister were all placed for adoption and the plan has been that the siblings not keep in touch. Jimmy does not have any ties with his natural family.

The natural father had a drinking problem but did work. His usual occupation was as a laborer or truck driver. However, he never used his earnings to support the family. The natural mother, of limited intelligence, was completely inadequate as a parent. Both she and the father were in rather consistent conflict with the law.

Jimmy's first foster parent was a widow. There was another infant in the home, as well as a young toddler and two other children. Jimmy remained there for about two years, until November, 1964. A succession of infants were boarded by the foster parent and as new infants were boarded, attention was focused on the new infants. It was felt that Jimmy suffered a lack of stimulation and lack of attention. Having been neglected already in his natural home, Jimmy began to show emotional symptoms at an early age.

On coming into care, Jimmy had a right inquinal hernia and a slight orthopedic problem. He "toed in". Before placement for Jimmy could have been considered, efforts were made to correct his medical problems and help him catch up to his proper developmental level. Surgery followed for the hernia and a Dennis Brown Splint was used for the orthopedic problem.

EXHIBIT #9-A-1

cont'd When the child was much less than two years old, he began "head banging". He was placed in a second foster home just prior to his surgery, and as emotional symptoms increased following the surgery, the foster parents decided they could not cope and asked that Jimmy be removed. Jimmy was seen by the doctor for nervous symptoms while in the second home. Then he was hospitalized in Aidmore just prior to removal from his third foster home. At that time he was "head banging, spitting and kicking", and again the foster parents felt they could not continue to keep him.

Jimmy made a good improvement in his 4th foster hom . In fact, he was beginning to act like a normal child. However, the foster mother developed a health problem requiring surgery, the couple's financial situation became strained as well, and they had to ask that their home be closed. Jimmy was moved to his 5th foster home.

He had been tested psychologically as an infant and again while in his last foster homes. There was much consultation and effort by the 4th foster parents to follow medical advice, though Jimmy was not involved in actual treatment or therapy. Jimmy's first test results placed him in low average intelligence range. However, later testings have not been so good, as Jimmy's insecurity and lack of motivation has grown.

In his last foster home before placement in CSH, Jimmy adjusted satisfactorily and was the only foster child for a year. Older siblings were placed in the home but did not seem to threaten Jimmy's position. Two young girls were then placed after the older children were moved. Though thrilled over having other children to play with to begin, Jimmy's jealousy began to grow. After a stormy period, marked by tantrums and bedwetting, Jimmy adjusted satisfactorily. During this time he was seen regularily at a local Mental Health Clinic. He also attended Headstart. When he entered the 1st grade, Jimmy did alright until his teacher retired and was replaced by a younger teacher. He then became such a disciplinary problem and was so disruptive in class, screaming, fighting,' pushing over desks, and so forth, that he could hardly be contained. He was on Dilantin medication and this was increased, but not with very significant results. At home Jimmy was bedwetting, distructive and again unable to stand competition from other children. He regressed in social manners and even had one episode of smearing feces. The foster parents finally reached the decision that they had done all they knew to do for Jimmy and asked that he be moved at the end of that school year (1970).

Jimmy's placement at CSH has seemed to be his most profitable placement yet. He has not been the extreme behavioral problem while there, that he has often been in the past. That has to indicate improvements. However, as is often the case, just because he has not been as much of a behavioral problem as at times in the past, is not felt to be indicative that CSH is the place for Jimmy to stay. On the contrary, CSH has for some months been requesting a long-term foster or adoptive home for Jimmy. It is felt that Jimmy will now only regress if he does not get a suitable home placement, and as soon as possible.

EXHIBIT #9-A-2

cont'd

Jimmy is in good physical health. A systolic heart murmur was found in 1970 but no pathology was evident and Jimmy's activities are not limited. Jimmy is up to date on immunizations and has had the following since admission to CSH: Tetanus Toxiod 7-2-70 and 9-2-70; Rubella Vaccine 7-14-70; Mumps Vaccine 1-12-71; Oral Polio immunization 11-18-70; and negative Tuberculine Tine Test 7-2-70. Blood testing (CBC) was performed 1-18-73 with results normal. Yearly physical exam also was normal. Jimmy had an electroencephalogram 7-1-70 with normal results. Recent dental check on 2-5-73 showed some dental cavities. Teeth were cleaned and restored.

CSH reports that Jimmy's school work in his special education class has been satisfactory. Consistent discipline has helped Jimmy to adjust. It is still recommended that he continue in special education on the primary level. Jimmy presently functions at about the 2nd grade level with slightly lower reading skills. He continues to show a low tolerance to frustration. He frustrates easily because he seems to be a "perfectionistic" in his performance, according to his teachers at CSH. Jimmy reacts, when frustrated by too difficult a task, by pouting, destroying his work, or crying. He can also have temper rage, still.

Jimmy has had many psychological tests in the past, including at least three while at CSH. His latest testing was on 12-22-71, and on which he obtained his lowest score, I.Q. 61. Previously, he had scored at 65 or 77 on I.Q. The discrepancy is associated with the differences in motivational levels at the times of testing.

The staff at CSH conclude that Jimmy is a mildly retarded child who has displayed an Unsocialized Aggressive Reaction of Childhood. Presently, his motivation seems to drop lower and lower. He frequently asks when he can go home - though he has displayed that he has no clear concept of who his parents are - how could he? In his anxiousness to have a home, Jimmy has made up fantasies, saying to others that he was going home with his parents in a few days.

Jimmy has visited in foster homes on holidays, and efforts have been made to no avail to develop a placement for Jimmy in his home county. Jimmy always wants to stay, when leaving a home after a visit. He has behaved rather well on these visits and remarked after the last, that he wished he could live with the foster family forever.

Current apparent behavioral deficits are short attention span, low frustration to tolerence, occasional enuresis, and lack of motivation to achieve. As previously stated, he can throw a temper tantrum. Jimmy has shown improvements and does function better than before.

As Jimmy's Social Worker at CSH has pointed out, Jimmy's main problem is that he has no parents and no past successes. It is felt that nothing would benefit Jimmy quite so much as closeness of relationship on a consistent basis. Jimmy needs structured support and freedom to "express negative feelings in a non-threatening atmosphere." He needs firm but compassionatediscipline and needs only expectations that he can "realistically" fulfill. Jimmy will have to have acceptance from authority figures. Due to his past failures, Jimmy has come to expect to fail. Prospective parents must have tolerance to accept initial "acting out".

EXHIBIT #9-A-3

Social Workers at CSH feel very strongly, as do we, that many factors indicate that now is the crucial time to place Jimmy, if he is ever to have another family home placement. Jimmy has received maximum benefit from Central State's program. He has turned ten and is not far from adolescence, and doubtless, if he is not placed before adolescence, he cannot be expected to adjust at that difficult time.

It has been brought out as "critical" that a home found for Jimmy not be one that is filled with other siblings, but one that would offer a long-term relationship with mature parents, possessing the insight to understand Jimmy's dynamics. The parents would have to be willing to give of themselves to meet Jimmy's needs. Finally, if possible, the parents should have opportunity for family counseling. CSH has offered to arrange for some such sessions. The parents would need to establish some type of behavior modification techniques, such as those to which Jimmy has been responding at CSH.

We do not know if such a home is available, or consequently, if this child will ever get a chance for consistency in a family home and the benefits it could provide him - but we desperately hope so. Only Jimmy wants that more so.

EXHIBIT #9-A-4

Case No.: 329

Date of Admission: 5-22-69

No. of Previous Admissions:

Date of Last Termination:

Aftercare
5-22-69
James Ramey was in for his appointment. Worker talked first with James and his foster mother, Mrs. Satterfield, together, then talked with Mrs. Satterfield, and the caseworker, Mrs. Bracewell, while James waited for us outside.

James is quite an attractive youngster although he was obviously very insecure. He was so timid and shy he would hardly answer even simple questions, but would look to his foster mother to answer for him. There is quite an adequate social history provided for us by the Family and Children Service who referred the child to our agency, so worker spent most of his time discussing some of the current problems that concern the boy.

He is obviously an angry child. The mother seemed amazed that he delighted in spending long periods of time simply knocking down and beating up old corn stalks. He likes to throw rocks and will spend long periods of time cutting up paper when permitted to do so. Worker tried to help her gain some insight into some of the contributing factors to the child's anger and discussed with her ways of helping him learn to express it in a controlled, safe fashion, emphasizing the child's need to learn to feel accepted even though he is an angry person. She also discussed his obvious negative self-image. When he first came to the home, he would announce to the company who came in that he peas in the bed. She finally has gotten him to cease this kind of behavior, but he still wets the bed. Sometimes he will go for a while without doing so but recently has been wetting the bed every night. Upon one occasion he told her he was going to. She found the bed wet before he had ever been to sleep. She spanked him for this, but generally does not react in this fashion. She has essentially tried to ignore it as though it didn't matter. This is not working. Worker suggested she continue to be understanding about it and not take punitive action, but at the same time to let the child know that it is an unpleasant thing and that she really doesn't like changing wet beds.

James also seems to be a bit compulsive, from her description of his behavior, about leaving everything in order. She mentioned that when he plays he has to line up his toys in a perfect line, and that if he attempts a task and cannot complete it to his satisfaction, he becomes very frustrated, such as bed-making. He cannot tolerate a wrinkle left. Worker emphasized to her approaches that he felt might be helpful to the mother in her efforts to develop a more positive self-image in the child, explaining to her that it is a slow difficult process, and suggesting she make real efforts to compliment him but avoid trying to convince him forthwith that he is a good boy, but instead to approach it in a step-by-step basis commending him for his achievements rather than drawing from them the major conclusion that he is therefore a good boy. She seemed interested in some of these ideas. Worker felt she likely can use them with some success in her efforts to help this child. She accepted another appointment to discuss the situation with worker again June 19 at 10:00 A.M.

Norman F. McFarland, A.C.S.W.

EXHIBIT #9-B-1

6-19-69
Worker talked with Mrs. Satterfield, James Ramey's foster mother, and then with James. It seems there has been some improvement. The problem with James wetting the bed seems to have subsided considerably. They have also tried ignoring some of his objectionable behaviors and found that this has been helpful with some of the problems. However, many problems remain. Mrs. Satterfield seems to understand this and is willing to accept the fact that therapy with this child is going to be a long-term proposition.

She reports that he has been attending Vacation Bible School. This has evidently left him so high that he has had a difficult time getting to sleep and has been up until two or three o'clock every night. She also reports that she can tell no essential difference in his behavior when he takes the medication that the doctors prescribed and when he doesn't. He has manifested anger toward her a couple of times. Worker discussed this with her and suggested that she continue to even encourage him to express some of his anger toward her and toward others so long as he does not do it in extreme fashion. She is already aware that he has strongly tended to turn all his anger inward toward himself and his own things. Worker tried to help her see the need to develop the capacity to express anger in a controlled fashion toward other people and things than himself.

We also discussed at length his need for perfection. Worker gave suggestions to her to help him learn to tolerate such things as a bed with a few wrinkles in it and also suggested that she encourage him to be himself, as she was already beginning to do, by pointing out to him that he doesn't need to simply mimic the other children. She had noticed at the table he watched one of the other children and ate exactly what they ate when they ate it. She also talked about his extreme neatness. Worker suggested she help him have more play children's play that involved him in getting dirty and that she encourage him to work with her in the yard and in the garden and such things as this where he would be able to get dirty and hopefully learn to do so without becoming frustrated.

She seems to have a very warm feeling for this child and is very interested in doing everything she can to be helpful to him. Worker felt she is also capable of using ideas and suggestions offered to her quite effectively.

Another appointment to see James and Mrs. Satterfield two weeks later was scheduled.

Norman F. McFarland, A.C.S.W.

7-2-69
Worker talked with James Ramey and then conferred with his foster mother, Mrs. Satterfield. Over-all it seems James continues to improve. The people who are working with him in Headstart this summer have noticed a great deal of improvement over his behavior in comparison with the previous year.

Mrs. Satterfield speaks of James having what she views as a dual personality. She goes on to describe him as extremely hostile at times and extremely tender and loving at times. She illustrated this by describing the different ways he reacted at the Family and Children Service agency and another agency where he had been taken for testing. The Family and Children Service agency found him almost unbearable, and at the other agency they found him quite cooperative and lovable. Worker suggested it is likely that with the Family and Children Service being involved in the many transfers that this child has gone through in his few years, he has come to view them in rather hostile fashion. It was pointed out that because he is extremely emotional, his reactions are more pronounced than would be in a more normal child. However, since these reactions of an extreme nature seem to be coming less often and with perhaps some small degree of lessened severity, worker suggested it is therefore hopeful that this is a problem that understanding and development will, in the main, reduce to more nearly normal proportions.

EXHIBIT #9-B-2

He continues to wet the bed at times and stay dry at times. Mrs. Satterfield feels that he is no longer using this as a method of getting even. She bases this primarily upon her observation that he tends now to wet the bed more often when he is actually sleeping better. He still continues to have difficulty sleeping and will often stay awake until after midnight.

He also continues mimicking the other children in the home, especially the little girl that he admires most. Jimmy is also beginning to express more anger. The foster mother says she has, insofar as she could, simply been ignoring his expressions of anger so long as they are not extreme. Worker supported and encouraged her in this. We also discussed ways to devise a step-by-step plan of helping him learn that he does not need to mimic others in order to be safe and accepted. We focused particularly on his eating habits. Worker suggested she might first begin by letting him mimic one of the other family members rather than the little girl that he has mimicked so consistently, and perhaps then go on to suggest that he take the first bite sometimes and that she will follow his example.

Mrs. Satterfield still had some negative feelings about Jimmy being kept out of regular school this past year. Worker tried to help her see that it likely was a wise decision in view of the problems that he is coping with. Worker suggested it would be much easier for him to learn to cope more successfully with his emotional problems if he can be in some position in his class other than one of being constantly at the bottom or behind. Worker suggested that since he is a year later starting, perhaps he will find it easier to achieve and that this will expedite his efforts to mature emotionally.

Someone had mentioned the possibility that we might want to consult with her and see James on a weekly basis. She felt this would be quite difficult in view of the distance involved. Worker also agreed, in view of her seeming competence and the continuing over-all direction toward improvement that James seems to be manifesting, that it would not be necessary at present to think in terms of weekly visits. After some discussion, we scheduled the next interview for July 31 at 10:00 A.M.

Norman F. McFarland, A.C.S.W.

7-31-69
Worker talked with James Ramey by himself, then talked with his foster mother, Mrs. Satterfield, while James waited outside. James is still rather reluctant to become involved with worker. He stated that he didn't want to talk although he would talk a bit when invited to discuss games he had played at Headstart and such things as this. He was also very interested in playing games with worker. He was curious about the paper holder. Worker allowed him to cut some paper with the paper holder. He seemed to enjoy this immensely and wanted to continue it. Worker explained he didn't have other games to play but would try to have some when he comes again.

In talking with Mrs. Satterfield, she feels that there is continuing progress. She says that the Headstart teacher has the same view of James. He is still some trouble but much less than previously. The mother also reports that he has loosened up enough to where he will finger paint and get himself pretty messed up in this fashion without being bothered about it. He also is less prone to mimic the girls who are also a part of the foster family. He is finally beginning to like the Headstart program.

He is also beginning to have tantrums when he cannot get his way. Worker discussed at great length with Mrs. Satterfield ways of coping with this behavior, essentially suggesting that she ignore it as far as is feasible and that she not insist on his stopping it immediately even when it becomes intolerable, but instead shift him to another room or even out in the yard, inviting him to continue until he is through and then return. Worker went on at some length to support her in the necessity of setting limits to help her feel free from any guilt in setting necessary realistic limits. Worker pointed out

to her how these are just as essential as his being given some freedom. She still maintains a very warm feeling for the child and seems to be gaining a real sense of achievement in this boy's seeming continuing progress.

Another appointment to see her about a week and a half after school starts was scheduled. He will be seen Thursday, September 4 at 10:00 A.M.

Norman F. McFarland, ACSW

9-11-69
Worker talked with James Ramey and his foster mother, Mrs. Satterfield in separate interviews. James didn't want to talk. He sat rather quietly making obvious efforts not to respond. However, when worker sought to engage him in some activities, he responded readily. He drew a picture of a man's face, wrote some figures on a sheet of paper, and put a puzzle together. He started off well but became a little anxious when he couldn't find the third piece to place readily. Eventually he was successful in putting the puzzle together in a quite reasonable period of time. We also played with a ball a considerable amount. He became quite excited about this and obviously enjoyed tremendously hitting the ball and he was especially thrilled when he hit the ball so fast that it hit worker. He also showed surprisingly good coordination in throwing the ball at the waste paper basket. He remembered the game we had previously played cutting paper with the latter opener and wanted to repeat this. He pushes limits and wants to continue playing whatever he is playing and test worker out to see if he will enforce any limits.

The explosive release of his feelings in these play situations suggests that this young boy is likely having a terribly difficult time coping with a lot of very deep feelings.

Later.
In talking with Mrs. Satterfield, she focused in the main on her worries about James being placed in a special education class. It seems that there may be some reality to some of her concern, since the class was just being organized. He was in with just two other pupils for a while and then other pupils were placed. She feels very strongly that this made a tremendous difference in James' attitude. Because of the depth of her own feelings, worker wondered, however, if she were not projecting a great deal of her own feelings about the special education situation onto Jimmy. Worker encouraged her to ventilate her own feelings about this at some length and assured her that several psychological tests were in basic agreement that this seemed like sound planning. Worker further pointed out to her on the basis of his own knowledge of the child and on the basis of her own reports that it seems certain that Jimmy has multiple serious emotional problems that would make it extremely difficult for him to function successfully in a regular classroom setting, even if he were normal or above normal. Worker emphasized to her Jimmy's extreme fears and his obvious need for being successful and suggested that a special education setup was much more likely to provide some of these very basic needs. Worker suggested that they were more fundamentally important at this point in Jimmy's life than the amount of reading or arithmetic skills he mastered. She seems perhaps a bit reconciled toward the end of the interview, but it is still obvious that she just has not really made her peace with this special education placement plan.

Another appointment to see James September 29 at 10:00 A.M. was scheduled.

Norman F. McFarland, ACSW

9-19-69
Worker talked with James Ramey and then later talked with Mrs. Satterfield, the foster mother. James seems a little more open and a bit more ready to relate to worker, although he still primarily wants to play. He again wanted to cut papers as we had in previous interviews but seemed a bit more angry and hostile in his cutting papers.

Worker had him write some for him. He started off by making a fairly good 4 and a 5, but when he attempted to make an eight, he got out of the lines, became frustrated, tried to erase it, then wanted to quit, and was pretty firm in his refusal to work anymore. He was also able to write his name fairly well except for the fact that he omitted the letter "i" and simply wrote "Jmmy". He still obviously enjoyed hitting the ball and seemed especially happy when worker held the ball so it became something of a punching bag.

Mrs. Satterfield is still worried about his being placed in special education. She reports that he seems to be regressing. He is mimicking other children a great deal. He seems to be withdrawing from involvement with other children. She reports that he has chosen as the one friend that he seems to really want to be with, the most severely handicapped child in the class whom she describes as having strong Mongoloid characteristics. She says that he is showing more anger and aggressive behavior toward the little girls who are also in the foster home.

He continues to have these difficult times at night that she describes as "night terrors" and he seems upset sometimes the day before and sometimes the day following recurrence of these. At times he simply refuses to cooperate. The teacher was quite frustrated by this at a time when they were having a fire drill. He said he didn't know where they were going and he wasn't going. She finally had to remove him physically to secure his cooperation in the fire drill.

Satterfield
Mrs. Ramey seemed convinced that had he been left in a regular class where according to her reports he did quite well the three days he was there, that none of these problems would have occurred. Worker suggested that there were several reasons for thinking that he likely would have run into difficulties, perhaps even more in the standard classroom setting. Worker pointed out to her how difficult it was for him to stand failure and illustrated this by how he had refused to continue working when he made a mistake and got out of the lines. She could pick up on this and realize that it is extremely difficult for this child to tolerate anything out of order or any kind of failure. Worker pointed out he would inevitably have faced more of these kinds of things in the standard classroom setting and would have received less attention and understanding when he did fail to achieve than is true in a special ed situation. She seems somewhat reconciled to his being in special ed but is still angry at the school. She feels that one of the other children who is now in the second grade actually has less reading ability than Jimmy does.

Another appointment to see Jimmy Thursday, October 9 at 1:30 was scheduled.

Norman F. McFarland, ACSW

11-13-69
Worker talked with James Ramey, then talked with his foster mother, Mrs. Satterfield. James seems to be adjusting more readily to worker. He accepts limits without pushing quite as hard in testing to see if worker will enforce them. He still is obviously an angry little fellow and still tends to manipulate, but seems to be more nearly able to respond in a positive way to worker in the interview situation.

Mrs. Satterfield reports there have been some downturns. She feels this was caused in part by the fact that his teacher at school was out for a week and he had to have a substitute. This has been accompanied also by more bedwetting and he has on a couple of occasions tested her out in a more severe fashion than he had been accustomed to

EXHIBIT #9-B-5

ding. It seems, however, she set her limits and maintained them in a firm fashion. Worker upheld her in this.

She reports that he is achieving quite well in school. His teacher feels that he may be ready for the regular second grade level work next school year. He still, however, has some difficulties in school and reacts in rather extreme fashion at times. On one occasion a child attempted to choke him. He panicked and was unable to really work at his school work the whole day. He spent the entire day making black heavy marks on paper.

Mrs. Satterfield seems to have adjusted to his being in the special education class for this school year, and no longer seems to be seeking any change in this area.

Another appointment was scheduled for December 10 at 2:30 P.M.

Norman F. McFarland, ACSW

12-10-69
Worker saw James Ramey and then talked with the foster mother, Mrs. Satterfield alone. It seems that James has had a bit of recession. He was sick for a couple of weeks and seems to have regressed following this. On one occasion he bit his hand and there was still quite a scabbed over place indicating quite a sore. He also bit the buttons off his shirt. These behaviors had not occurred for some time. There were other behaviors indicating regression to more childish or primitive ways, but there seems to be some lessening of this trend as his physical health improves.

Mrs. Satterfield seemed somewhat reassured with worker's interpretation of his regression. He suggested that the interpretation can be checked out by observing whether or not the condition improves gradually as his over-all health returns to normal.

Another appointment to see them a month later was scheduled.

Norman F. McFarland, ACSW

1-29-70
James Ramey was in for his appointment. He seemed a bit quieter and more willing to sit and talk, although he was still obviously quite angry. He seems to have gradually become more accepting of worker. However, it seems there continues to be fluctuation in his over-all life adjustment. Mrs. Satterfield reported that he had been up until 3:00 A.M. the previous night. He had been having trouble with nightmares and what she terms "night terrors". He finally managed to get to sleep about three. This is the first time in several weeks that such an episode has occurred.

Mrs. Satterfield also relates that he has frequently expressed the wish that he were a baby recently. He has said he wishes he were a baby girl and especially her baby.

Another appointment to see James a month later was scheduled.

Norman F. McFarland, ACSW

EXHIBIT #9-B-6

MAY 1 S 1970

3-4-70
Worker talked with James Ramey, then talked with the foster mother, Mrs. Satterfield. James seems essentially the same. He had become more over-active at school. The local physician had increased his medication. This seems to have helped some. However, the foster mother reports that when things seem to quiten down at school, he seems to have night terrors more frequently.

With a view to helping plan James' educational future and further efforts at therapy, psychological evaluation was scheduled for April 7 at 12:30.

Norman F. McFarland, ACSW

4-21-70
James was seen by Dr. Cole today. No notes were dictated.

4-21-70
Worker visited briefly with James Ramey while he was waiting to see Dr. Cole. He seemed angrier than usual and was quite hostile and aggressive. He threatened to overturn the ash tray in the floor and in general was more provocative than usual.

Later. Worker also talked with Mrs. Satterfield, the foster mother. She is apparently becoming discouraged with the prospect of being able to keep James. She reports that he is becoming much more destructive in his behavior. Instead of focusing it most of the time on himself and his own things, as he had in the past, he is beginning to be destructive toward other people and other people's property. She reports that he had quite thoroughly shattered over 100 of her mother's canning jars on one occasion. He also is attempting to destroy the other children's toys unless he has one just like it.

Since he is to be seen by Dr. Cole for at least another interview, no further appointments were scheduled by social worker.

Norman F. McFarland, ACSW

5-6-70
This is the second time I have seen James although no notes were dictated on our first meeting. As a matter of fact, the first meeting consisted mostly of talking with the foster mother. She described James' behavior as one of destructiveness, aggressiveness, and hostility toward girls. The first time I saw James he was rather reluctant to talk but did not engage in any aggressive or hostile behavior. As a matter of fact, he seemed quite calm and quite willing to go along with the examiner. However, he did display some passive-aggressive behavior, refusing to answer questions that it was fairly obvious that he knew the answer to.

Dr. Florene Young tested James in May of 1969 and obtained an IQ score of 69. She expressed the feeling that this was not his optimal performance and that he could possibly perform up to the dull-normal level.

Today I saw James for approximately 45 minutes and during this time he displayed some of the aggressiveness that his foster mother had talked about. For example, he was constantly fiddling with things on my desk and it was necessary to exert control on several occasions. He responded well as long as the examiner let him have his way, but as soon as he was told that he could not do anything, he pouted and responded with some aggressiveness. Although it is fairly obvious that James is an emotionally disturbed child, there is enough evidence to make one suspect some cerebral impairment. The foster mother claims that the pediatrician told her that he had some type of epilepsy but she has never seen him have a seizure. I am having Dr. Curtis examine Jimmy on the basis that it might be profitable to have him

prescribe some drugs that could possibly alleviate some of his symptoms.

It is fairly apparent that James has difficulty in controlling himself and has to depend on others to do the controlling for him. It is suggested to the mother that she respond to James in a fair but always firm manner. If given the opportunity to express anger without limits, James becomes quite upset and quite destructive. He should be told exactly what he can do and then these limits should be adhered to rather rigidly. Both James and his foster mother will return in two weeks.

Spurgeon Cole, Ph. D.

5-26-70
This young man is having an acting out problem. He basically acts out in an aggressive fashion and is sometimes almost uncontrollable in his behavior. However, he seems to have made considerable progress since staying in the present foster home. The present foster mother seems to take a very firm but loving approach with him, which I think is very desirable. The difficulty in school I think has been that the teacher which he has now is not able to deal with his acting out behavior in as realistic a manner as the one that he had previously. It is my recommendation that he be placed in a school where there is a relatively firm, reasonable disciplinary policy which is consistently applied. I would also feel that it would be of benefit to him if he could stay in the foster home for an additional year since he has been in seven different foster homes and I feel that this must be very upsetting to him and if he has to move, it would be even more upsetting to him. I do not feel that medication is indicated or would be of much value since as much medicine as would be required to tranquilize him would essentially knock him out.

John R. Curtis, M. D.
Psychiatric Consultant

EXHIBIT #10

A. Psychological Evaluation

B. Intelligence Re-Evaluation

C. Restaffing

PSYCHOLOGICAL EVALUATION

NAME:
CASE NO.: 17j617
AGE: 10 years, 11 months
BIRTHDATE: 8/14/62
COUNTY: Stephens

WARD: Children's ' South
ADMISSION DATE: 6/26/70
DATES OF EXAMINATION: 8/3/73, 8/9/73
DATE OF REPORT: 8/9/73

BACKGROUND INFORMATION: Jimmy is in the custody of the Stephens County Department of Family and Children Services, and has been hospitalized for the past three years in the Children's Building. Attempts to encourage this agency to actively seek a placement for Jimmy have been unsuccessful. He was last evaluated in December 1971, and the observations and conclusions in that report are considered valid at the present time, with the exceptions noted below. Jimmy has worked with a large number of therapists during his hospitalization, and reports of his treatment program and progress are contained in the ward chart.

TESTS ADMINISTERED: Wechsler Intelligence Scale for Children, Wide Range Achievement Test, Bender Visual-Motor Gestalt, Children's Apperception Test.

TEST RESULTS AND OBSERVATIONS: The results of Jimmy's performance on four IQ test administrations are given in the table below.

DATE	TEST	VERBAL IQ	PERFORMANCE IQ	FULL SCALE IQ
7/2/68	S-B			74
7/2/70	WISC	79	81	77
11/10/71	STANFORD BINET			66
12/15/71	WISC	65	64	61
8/4/73	WISC	71	67	66

5/1/68 S-B IQ=69
7/28/68
FS=7

As previously, Jimmy's performance in [illegible] of motivation, which was lacking during the 1971 administrations. However, during the present administration, Jimmy again seemed highly motivated. He persisted in his usual tendency to give up easily, but the performance shows little scatter, and there is no reason to believe that his potential to perform is any higher at this time. He is functioning within the Mild Retardation range of intelligence.

On the WRAT, Jimmy obtained the following grade level equivalents: reading, 1.8;

EXHIBIT #10-A-1

spelling, 2.2; arithmetic, 2.6. These results show a grade level increase ranging from .3 in reading to .9 in spelling, over the past one and a half academic years.

Jimmy's reproductions of the Bender designs showed a great increase in maturity and organization over prior testing, but the results were inconclusive in regard to identifying possible neurological deficits involved in perceptual-motor functioning.

Jimmy's responses to the CAT cards revealed the degree to which he has internalized the institutional routine. He verbalized no conflicts, and emphasized a routine of daily living which includes sleeping, getting up, eating, playing, eating, sleeping, etc. He showed a disinclination to project himself into situations which normally elicit dynamics related to a child's role in the family. He sees the mother as meeting the needs of the children, and the children as obeying the mother. Jimmy has apparently developed strong defenses against the hurt evolving from his deprivation of familial stability and emotional security.

SUMMARY AND RECOMMENDATIONS: Jimmy's behavior during the past two years has consistently been that of a mildly retarded child with very poor self-esteem and high level of frustration at his inability to compete effectively with his peers, or to meet his own unrealistic standards. However, during the past three months, Jimmy has undergone a large number of success experiences in the classroom and in his relationship with his therapist. His confidence in himself, although still limited, has increased, and he shows less tendency to be intropunitive and rejecting of himself. With the exception of a local family who has taken Jimmy for weekend visits [illegible] past two [illegible] Jimmy has had no [illegible] outside the hospital. It is felt that efforts to obtain a foster placement should be primary at this time, lest Jimmy become a permanently institutionalized child.

G. Robert Dixon
Senior Psychology Technician
Children and Adolescents Unit

Lee C. Groves, Ph.D.
Clinical Director, Psychology
Children and Adolescents Unit

/th

cc: Record Room, Ward Chart, File.

EXHIBIT #10-A-2

NAME: James Ramey
[illegible]
[illegible]
BIRTHDATE: [illegible]
COUNTY: Laurens

[illegible]

REASON FOR TESTING: Re-evaluation of IQ for possible [illegible] treatment unit.

PHYSICAL DESCRIPTION AND BEHAVIORAL OBSERVATIONS: Jimmy is always neatly groomed & well-dressed. He is a well-developed, 12-year-old, freckle-faced, red-headed boy. His affect is flat; psychomotor activity is within normal limits though slightly exaggerated. His mood is fairly stable, but when he becomes frustrated it is volatile. He is oriented in time and place, and the nature of his interpersonal responses is best described as concrete and relating to the immediate environment (though some talk has been oriented toward forthcoming school vacation periods). This ideation is that of a mildly retarded child; some perseveration is evident in his actions and speech. No evidence of psychosis or neurosis is evident, but he does show acute reactions to frustrative stimuli.

TESTS ADMINISTERED: Stanford Binet Intelligence Scale, Form L-M.

TEST RESULTS: Jimmy achieved an IQ of 60, which corresponds well with his previous score of 65. This score places him in the Mild Mental Retardation range and is felt to accurately estimate Jimmy's level of functioning.

He has a short attention span, lacks concentration, and seems to give up easily. He does show the ability to "think out" problems which do not require much attention, but even then, he still seems to require urging to complete the task.

SUMMARY AND RECOMMENDATIONS: James Lamar Ramey is a Mildly mentally retarded 12-year old boy. He has been in the Children's Building for four years though a more appropriate treatment program has been indicated for some time. His only behavior problem is his acute reaction to frustrative stimuli, however, this is not an uncommon characteristic of mildly retarded children.

James has achieved maximum benefit from the treatment program [illegible] Central Georgia Regional Hospital and it is strongly urged he be transferred to the appropriate developmental center, in his case, Georgia Retardation Center in Atlanta. The Stephens [illegible] contacts [illegible] either group or foster [illegible]. Any temporary [illegible] to the parents the need for limit-setting and [illegible] difference [illegible] they (the parents) lay down initially. Jimmy can function appropriately if this is done, but if rules can be bent, he will take advantage of the opportunity.

David Coron, Psychologist
Children and Adolescents Unit

Marilyn Edmiston, Ph.D.
Clinical Director, Psychology
Children and Adolescents Unit

/th

cc: Ward Chart, File.

EXHIBIT #10-B

BEST COPY AVAILABLE

RESTAFFING - 11-27-74 - Jimmy Raney

WARD PROBLEMS
1. Poor socialization with peers
2. low frustration level
3. bed wetting
4. teasing and provoking peers (improved some since admission)

COMMONLY SEEN BEHAVIOR
1. keeps himself clean and room neat
2. helpful on ward
3. temper tantrums
4. plays poorly with others (is improving)

TREATMENT METHODS
1. continued placement in school of special education
2. recreation and music therapy
3. placement in groups to increase socialization
4. program to reduce bed wetting
5. repeat EEG
6. Plan for foster care placement

GOALS AS INPATIENT
1. increased frustration tolerance
2. decreased bed wetting
3. increased socialization with peers

GOALS AS OUT PATIENT
1. Placement in foster home
2. adjustment to and continued attendance to community school of special education

EXHIBIT #10-C

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

MACON, GEORGIA 1:30 P.M. NOVEMBER 25, 1975

Deposition of Eli Charles Messinger, witness called by the Plaintiffs for the purpose of discovery and other legal purposes; taken by Lee Ellen McDaniel, Georgia Certified Reporter T-128, at 806 Georgia Power Building, Macon Georgia, beginning at the time stated above.

APPEARANCES:

For the Plaintiffs: GEORGIA LEGAL SERVICES
653 Second Street
Macon, Georgia 31204
Mr. David Goren, of counsel

Also appearing: Mr. Steve Granberg
Ms. Nancy Lindbloom

[2]

STIPULATION

For the Defendants: DEPARTMENT OF LAW
132 Judicial Building
Atlanta, Georgia 30334
Ms. Dorothy Y. Kirkley,
of counsel

Also appearing: Dr. Douglas Skelton

STIPULATION:

Deposition being called by the Plaintiffs for the purpose of discovery and other legal purposes. All formalities are waived. All objections except as to the form of the question

will be reserved until December 20, 1975, when they will be filed in writing to the Court. Witness and counsel agree to waive the right of the witness to read and sign the deposition.

ELI CHARLES MESSINGER

witness, first being duly sworn,
testified on

DIRECT EXAMINATION

BY MR. GOREN:

Q State your name and address.

A Eli Charles Messinger. 66 West 87th Street, New York, New York 10024.

Q What is your profession?

A I am a psychiatrist.

Q Are you certified to practice child psychiatry?

A I'm certified as a general psychiatrist and as a child psychiatrist.

Q What formal education have you had in this field—[3] what degrees have you earned?

A I earned a medical degree at Harvard Medical School; I had a year of medical internship at Grace New Haven Hospital in New Haven, Connecticut, which was associated with Yale Medical School. I had four years of psychiatric training at Bronx Municipal Hospital Center, Bronx, New York, which is associated with Albert Einstein College of Medicine—two of those four years of psychiatric training were in child psychiatry specifically.

Q Do you hold any academic titles?

A I am currently an Assistant Professor of Psychiatry at New York Medical College.

Q Could you describe for us your experience relative to child psychiatry?

A I've been in the private practice of child psychiatry part time since 1966 when I completed my training in child psychiatry. I've also been in the practice of general psychiatry. From 1966 to 1970, I worked half time at Montefiore Hospital, Bronx, New York, in the Department of Psychiatry. My main responsibility at that time was offering psychiatric consultation to the Department of Pediatrics at that hospital. From 1970 to September, 1974, I worked full time at Neighborhood Health Services Program—that's a federally funded comprehensive health care program in Manhattan, New York. I was a staff psychiatrist and later Director of the Mental Health Unit [4] there. I did community psychiatry, some administrative work, but mostly direct patient care of both children, adults and families. Currently, I am Director of the Child and Adolescent Psychiatric Clinic at Metropolitan Hospital, which is a large publically funded city hospital in Manhattan.

Q Have you written any articles or studies?

A I have.

Q What are they?

A I have written an article on the institutional treatment of the youthful offender—that was at a time when I was serving as Chief Medical Officer and Psychiatrist at a federal reformatory in Oklahoma. I have written more recently on drug treatment in children, specifically about Ritalin, which is a behavior modifying drug used in the treatment of certain childhood disorders.

Q Do you belong to any professional associations?

A I've been a member of the American Psychiatric Association since 1964. I'm on the Board of Directors of the New York Council of Child Psychiatry; I'm on the Board of Directors of Physicians Forum.

Q Can you describe your present position and duties and responsibilities you have in that position?

A I hold two titles—my clinical responsibilities are as Director of the Child and Adolescent Psychiatric Clinic at Metropolitan Hospital; my academic responsibilities are as [5] an Assistant Professor at New York Medical College. I am responsible for all the clinical services offered in a busy, fairly large psychiatric out-patient clinic serving children up to the age of eighteen. Part of that responsibility is the emergency services; that is, the evaluation for possible hospitalization of children, more often, teenagers, who are seen on a walk-in basis in our clinic, or in the emergency room of the general hospital of which we are a part. I am also a consultant to the Psychiatric In-Patient Service at Metropolitan Hospital which has fifteen, sixteen and seventeen year old children on its wards.

Q Do you have any particular familiarity with the admission of juveniles by their parents or guardians to public mental hospitals?

A Yes, in my current position I either evaluate directly or more often, supervise the work of child psychiatric trainees in the emergency evaluation of children and adolescents, and so I'm called upon typically several times a week to offer advice about the possible hospitalization of children to our facility or if there is no room at our facility to another public psychiatric facility.

Q Doctor, now I would like to ask you some questions concerning the role of parents in the admissions of children. What is your opinion in regards to the problems which lead parents to seek the hospitalization of their child in relation to [6] any difficulties the family itself may have?

A It's virtually impossible to evaluate the disturbance and needs of the child apart from understanding the disturbance and needs of the entire family. I think it's by now a truism in child psychiatry, a truism built over maybe fifty years of clinical experience in a wide variety of settings, that the pathology of children is inextricably related to the pathology of the family. Oftentimes, the disturbed or disturbing behavior shown by the child is best viewed as a communication or signal of distress to other members of the family, sometimes to people outside of the family.

Q Do you often find that parents as well as the child might need psychiatric help?

A That's true more often than not; it's usually clinically erroneous to focus one's attention exclusively on the child, rather than to consider the communication problems between member of the family, the adaptive or maladaptive balance that has been worked out between members of the family; and even when, in fact, the child shows evidence of significant psychopathology, it's important both in understanding the genesis of that psychopathology and formulating a rational treatment plan to work very closely with the parents. One of the reasons that I think that hospitalization should be used only as a last resort in the psychiatric care of children is that the extrusion of a child from the family to an institutional setting in many [7] ways precludes the possibility of work-

ing with the family. The two most common modalities of treatment used in working with the family is either parent counseling, which one works with father or mother or both to help them better understand the needs of their child or what's called Conjoint Family Treatment, in which one gathers together all members of the family and works to understand the communication gaps, distorted role allegations in the family; but, it is very rare that either of those kinds of treatment are practiced in a hospital setting, particularly when that hospital is some distance from the community where the family lives. Even when intentions are good, the fact that the child has been removed from the family often artificially quiets the situation down so there is a sigh of relief breathed by the parents and a troublesome child might indeed no longer be troublesome because no longer physically present. If, however, the child is returned to the family the same pathological interpersonal forces are at work, so the likelihood is that the same kind of pathology will be stirred up again.

Q Do you ever find in your experience that often the family may blame one particular member of the family for the problems that exist throughout the family?

A That's commonly known in psychiatry as "scapegoating" and it's a phenomenon that I have certainly seen. The mechanism here is that impulses or wishes or undersirable personal characteristics which the parent wish to defend themselves against are [8] projected onto typically a child chosen for a variety of reasons I mean, which child is chosen depends oftentimes on chance circumstances and then the child is treated as if indeed he was the vehicle of those undesirable characteristics. Sometimes this kind of role allocated works so well that the

child indeed begins to pick up such characteristics and it becomes a vicious kind of reverberating circuit.

Q In these kinds of situations, do you ever find that families can, in fact, mask their true feelings towards one another?

A Yes, indeed; I mean, families are pass masters at masking their true feelings towards one another—not as a deliberate, conscious attempt at deception, but really as a means of preserving some kind of sense of well being for themselves because they must live so intimately with one another. But this makes the task of the evaluating psychiatrist terribly difficult because unless the evaluating psychiatrist has had a chance to work with this family over an extended period of time the more subtle undercurrents of pathology might not be obvious. There's a term used in psychiatry to cover this kind of situation I believe coined by a psychiatrist particularly interested in family pathology—his name is Wynn—and it's called pseudomutuality.

Q In situations where, as you described, there may be scapegoating or there may be this pseudomutuality . . .

[9]

A Yes.

Q Is it possible that families . . . parents in relating facts to a psychiatrist will actually misperceive or misinterpret facts?

A That certainly happens . . . one doesn't expect family members to be entirely rational and objective in their perceptions of other members of the family. That's going to be even more true in a crisis situation, and it's usually a crisis situation that brings a family to request

admission for a youngster; still another factor which is particularly at work in families where there are adolescents is that there is a generation gap and the behavior of the adolescent is misunderstood or ill tolerated by the parent generation—that behavior is often seen by the parents as a sick or deviant behavior when in fact, it might be quite in keeping with the subcultural values and behavior patterns of the teenagers of that day, and there are many obvious examples that come to mind in terms of dress, hairstyle, dating patterns, etc.

Q In the parent's seeking of psychiatric assistance, is there a tendency for a parent to overemphasize any pathology that may exist in a child?

A Yes, because the parent is looking for a certain kind of response from the mental health professional that they qualify or the mental health facility that they call upon. If they have in mind for good reason or poor reason that their child needs to [10] be in the hospital, wittingly or unwittingly, they are likely to color their story so that that's the response of the professional who they speak to. Also in a crisis situation, they are more likely to focus on the behavioral characteristics of the child that they find unpalatable or which they consider sick and deviant. My own experience is that if one can work out this crisis situation short of hospitalization and there are a wide variety of means of helping a family over such a crisis situation, that in the weeks that follow one often gets a rather different picture of the patient, that is, some of his or her more healthy characteristics—friendships that hadn't been talked about, good schoolwork that hadn't been mentioned, a good relationship with some other member of the family, might surface which heretofore had not been mentioned.

Q In a non-emergency situation, that is, where, for instance, there is not an imminent threat of physical harm to anyone, is it necessary for the child to remain hospitalized or to be hospitalized to make those observations?

A No, in fact, I think it is terribly important for the child to remain in the family and his or her usual life situation in order to gather the kind of data that would enable one to make a really complete diagnostic formulation of the case. If one artificially removes the child from the family, one in a sense, subverts the data gathering process. One can then . . . one loses a great deal of potential information.

[11]

Q You mentioned that parents may have a tendency to color facts in particular ways—how does this misperception of facts or this incorrect reporting of facts affect a decision to hospitalize a child?

A I would say that the single most important source of data to a psychiatrist who is in the position of evaluating a child for hospitalization is the parent's account. Children and adolescents generally find it hard to speak to a psychiatrist. It usually requires several meetings to get a good sense of the child's personality and for them to develop the rapport with the psychiatrist that enables them to talk more freely about their lives, their families, their fears. Secondly, if the child is being brought against his or her will, to the psychiatrist, they are very likely to see the psychiatrist as an agent of the parents rather than as someone who is likely to be sympathetic to their point of view. Thirdly, children have difficulties in communications—the younger the child, the greater the difficulties in communicating about the facts of their lives. Psychiatrists

tend to believe other adults more than they believe the accounts of children and I have seen my colleagues suddenly ignore or discredit accounts by children when they differ from accounts by parents, even when it might later turn out that the child's account might be closer to the truth.

Q An accurate reporting of the facts is essential in making a decision to hospitalize?

[12]

A It is essential, because the only other source of data that one has is the direct observation of the child—that's also of great importance, but as I said, it's . . . you do not have a representative sample of behavior. One takes a twenty minute, one hour, two hour segment out of the child's life . . . a child's behavior is very responsive to the setting, so that being in a doctor's office, being in a hospital, being taken to a doctor against one's will is . . . will have a major impact on the child's behavior and how he communicates with the doctor; so that the single most important source of information is, in fact, outside sources. Of course the psychiatrist should if at all possible, combine both sources of information. I have found, though, that if there's a discrepancy between the reports of the parents when they say the behavior is terribly serious, a discrepancy between such reports and actual observation of the child, the psychiatrist will air in the tendency of believing the parents, and that was true in the case of one of the patients in question today—Joey, whose behavior in the office did not bear out the complaints brought against him by the adoptive mother and her second husband. They described him as rebellious against authority or unwilling to listen to authority; yet, if we take the psychiatrist as an authority figure, the psychiatrist described Joey as cooperative and Joey answered the questions addressed to him and Joey went with him to the interview room, even though it meant separating him from his adoptive mother, [13] and Joey went with him to the day room to meet other children when he was asked to do so by the psychiatrist. The parents in that case also described him as very hyperactive, but hyperactivity was not noted during the admission examination.

Q Do you have any experience in dealing with agencies like welfare agencies or as we have here in Georgia, Department of Family and Children Services, when they are guardians of children in the state and seek to admit them to public mental hospitals?

A I do, in particular, I have experience with the Children's Center, which is in the catchment area of the hospital where I work—it's the only shelter for children in New York City at this time; and about half of our emergency psychiatric evaluations are sent to us by Children's Center.

Q In your dealings with that agency and similar agencies, do you often find that they make inappropriate requests for the hospitalization of children?

A From a medical and psychiatric standpoint, they are inappropriate. From the point of view of the institution, I can understand it, because institutions have needs that are analogous to the needs of a family, so that similar kinds of dynamics might lead to the extrusion of a client from an institution that in other circumstances might lead to the family wishing to extrude a member . . . a child to an institution. For example, in the evening and nighttime shifts in most institutions, there are [14] usually fewer personnel. The needs of children for emotional sup-

port if anything, might be greater in the evening hours, because of the dark, less obvious activity to keep them busy, fears about bedtime, and so forth. Many of our requests for hospitalization come during the evening hours. It's not because children develop mental illness in the evening, but because the institution's capacities . . . abilities . . . to deal with the emotional needs of children are less if their staffing patterns are less. Similarly, if a psychiatric part time psychiatric consultant is available to the institution, we are less likely to get emergency referrals than if we happen to hit a day or an hour when that person is not available. But the general point holds true that the institution's needs and the needs of the individual who is referred for psychiatric evaluation for hospitalization are not always the same.

Q Do you ever find that an agency would decide to request admission to a public mental hospital because there is a lack of other alternatives in their community or in their particular area?

A Unfortunately, that often happens, so that one often sees gray cases—neither black nor white—in which the child does not suffer from significant mental illness, but is a behavioral problem or a learning problem or a difficult child for which agencies will not take responsibility, so as the most expeditious bureaucratic maneuver the child is hospitalized; [15] and I think that's the case with the two patients that are in question in this case. Neither of them show evidence of serious mental illness—I don't either of them should be in a hospital. In fact, I think it's detrimental that they are in a hospital; but my understanding is that they have suffered in one case a five year, in another case a six year stay in the hospital because public or voluntary social agencies such as foster

homes, group homes, residential treatment centers have not offered to take such children. In fact, I think this becomes something of a vicious cycle because the very fact of their hospitalization works against the possibility of such agencies accepting a child, because most agencies become very worried that . . . when they hear that a child has been in a state mental hospital.

Q Given these interests that you've described that parents may have or that state agencies may have in decisions to request admission to a mental hospital for their children or wards, do you think psychiatrists in mental hospitals can act as effective checks on inappropriate requests for admissions?

A No. I say no for two reasons—first, hospitalization is a most serious intervention in the life of any person and certainly in the life of a child. For that reason, I believe that the state has an interest in safeguarding a potential patient; that is, I think that a . . . there should be a review by a nonpsychiatric body . . . of such a grave matter as the hospitalization of a child. Secondly, I think that there are built-in institu-[16]tional and professional biases, which psychiatrists have, which make them . . . which make it necessary to have another view of the child's needs from an other than psychiatric viewpoint.

Q Do you think that psychiatrists have tendencies, for instance, to overdiagnose particular illnesses?

A Psychiatrists tend to overdiagnose. They tend to focus on pschopathology. They tend, as a group, and I'm not saying this is true of everyone, to focus more on the child's sickness than on his assets and strengths. They tend to err on the side of hospitalizing patients rather than taking the necessary effort to work out a treatment pro-

gram in the home and in the community. It's oftentimes easier for a hospital based psychiatrist to simply admit a child, rather than taking the time and energy to work out a treatment program that would enable the child to remain at home. There's also often considerable pressure from the family or the school to get rid of the child, too; not necessarily in a malicious way, sometimes parents are overwhelmed. I believe, as someone who has worked in a community clinic and had occasion in the course of four years there to hospitalize only one youngster, I believe that it is possible in the vast majority of cases to work out treatment programs that are effective short of hospitalization.

Q What interest would some psychiatrists have—what per—self interest would they have to decide to hospitalize somebody rather than to try alternative treatments?

[17]

A I don't think the self interests are narrow and selfish—I think that they are self interests in terms of professional identity. Psychiatrists, as medical people, are used to hospitals; they are used to thinking that hospitalization is a good thing, whether a medical illness or a psychiatric illness. They are used to thinking in categories of pschopathology. They are generally not trained to make the most effective use of community resources; that is a relatively recent trend in psychiatry, and psychiatrists who have been trained some decades ago, or who are trained . . . have been trained themselves in a state hospital setting, or who have had little or no experience in community psychiatry, will err, I believe, in the direction of overhospitalization of youngsters. There's also some more personal anxieties and concerns that psychiatrists

have that if they allow a child to return to the family and some mishap occurs, anxiety that they will be blamed, that their name will find its way into the newspaper, that they'll be chastised by their supervisor—psychiatrists are human beings, too.

Q Let me ask you some questions now, Doctor, about the nature of the science of psychiatry—do you consider that to be an exact science?

A Psychiatry is not an exact science. Our . . . the material, if I can call it that, with which we deal and study, is too complicated for it to be reduced to the hard and fast categories of the physical sciences. We are often in an area [18] of judgment and even value judgment. As a case . . . let me go further . . . we have very few laboratory measures as to the medic . . . as to the physician who works in medicine or surgery. The information that we gather comes from other people who have themselves problems in communication and their own personal interests. We spoke earlier about parents not deliberately, but unconsciously, wishing to present a certain view of the situation. In terms of direct observation and examination of patients, there are numerous studies in the literature and it's everyday experience of all psychiatrists that there are widely divergent observations and diagnoses made on the same patient. Some of these divergencies in opinion come about because there are various schools of thinking in psychiatry; there have been different historical trends in psychiatry so that a diagnosis which was more popular some years back might not be as much in evidence today. For example, in child psychiatry, there used to be an entity called functional behavior problems of children. That has almost entirely gone out of fashion and is now called minimal brain damage. Two cases in point are the

two youngsters we are concerned about today—both of them had more than one diagnosis given to them at the time of admission—it was the same child, the same hospital, yet, they were rather discrepant diagnostic labels given to these children. For Joey, it was hyper-kinetic disorder and adjustment reaction of childhood. These are two different kettles of fish—one is not the same as the other, [19] yet, either the same psychiatrist or two different examining psychiatrists and I don't remember which, offered these two labels. In terms of Joey, one diagnosis was borderline mental retardation and literally the next page in the document, at least the document which I examined, had the psychologist check off "Not mentally retarded".

Q Do you mean Joey or Jimmy?

A Sorry—Jimmy. The second child.

Q This inexactness of the science that you've been describing—how does this relate expressly in regard to children or adolescents?

A Psychiatric diagnosis is a problematic area—the American Psychiatric Association, which puts out diagnostic manuals is in the process of currently revising it. If the diagnostic manual has to be revised every several years, we are not dealing with hard and fast categories in nature. The American Psychiatric Association recently decided that homosexuality was not a psychopathological state, but rather something else. Homosexuals did not change, but psychiatric attitudes towards homosexuality changed. Now the situation is compounded in childhood and adolescent psychiatry; no one is satisfied with the diagnostic categories which are in the diagnostic manuals available to us today. In fact, at our hospital, we use two

diagnostic classifications—one the so-called DSM2 and the other put out by People for the Advancement of Psychiatry. The [20] terms are radically different. Now a third factor which further compounds the difficulties and should make us, I think, terribly cautious about psychiatric diagnosis, is that adolescence itself is a time of very rapid psychological change, of turbulence, of mood swings, of erratic behavior, of extreme behavior, so that the very essence of adolescence is dangerously close to what psychiatrists consider mental illness; that is, it is a matter of rather . . . it's a difficult matter of judgment to distinguish between a normal adolescent and someone whose psychopathology brings them beyond the range—and it's a range—of normal behavior. This is a widely appreciated fact in psychiatry. All authors who have written about diagnosis in adolescence caution that it's a very difficult matter to make diagnoses in adolescence.

Q What you're saying, in other words, is that one doctor may diagnose a particular child or adolescent as, in fact, showing evidence of mental illness, when another psychiatrist, perhaps coming from a different school of thought, or having different training, may look at that same person and induce that there is no evidence of mental illness, but that the child is experiencing "growing pains".

A That is possible. I'd like to add to that that one of the most crucial kinds of observations made in a psychiatric examination is a description and an assessment of what's called "affect"; that is, feeling state. It has been my experience [21] that psychiatrists differ very markedly in their assessment of feeling states. I've had the experience of being in a teaching conference in which a patient was interviewed before a group of twenty or

thirty psychiatrists and other mental health professionals and to hear a wide variety of opinion as to whether the patient was anxious, angry, depressed, frightened, etc. And these kind of assessments are of considerable importance in making a decision about psychiatric diagnosis.

Q Could you describe for us in terms of its effect and nature, the differences between institutional treatment of an individual—individual psychiatric problems—as opposed to out-patient treatment in a community setting?

A My opinion—and it is shared, I believe, by the vast majority of psychiatrists in practice in the United States today—is that out-patient care is to be preferred for the treatment of psychiatric disorders. As you probably know, in the last ten or fifteen years, there has been a broad movement towards community based facilities. The thinking—and I share it—is that the least social disruption that occurs in the life of the patient, the better. This is especially true of children, where social development is a crucial variable and where continuity in terms of academic program in school, peer relationships in school and in the neighborhood, and most critically, the continued relationship with parents or parenting figures is of vital importance. Hospitalization has within it [22] certain inherent disadvantages—they include removal of the child from its natural setting, family, neighborhood, school. There are in addition, many aspects of institutionalization which are detrimental to personality development. Generally speaking, institutions run in a regimented fashion; they deal with numbers of people, so that procedures, regulations, policies, routines, schedules have to accommodate the needs of the staff in managing large numbers of patients rather than the more specific individual needs of the . . . of any individual person. I believe

that no matter how forward looking and progressive the institution, there is inevitably some tendency to sacrifice the needs of the individual patient for the needs of institutional efficiency.

Q What effect could that have on individual growth and development?

A A child needs to have the opportunity to say "Here I stand, these are my needs, these are my wishes, I don't want to or I wish to" and while these are not always ignored in an institutional setting, there is a tendency for them to be ignored more often than in a family setting or even in a less structured small group setting outside the hospital. Institutionalization also decreases self-esteem; it often undercuts individual self-initiative. In my work with patients—both children and adults who have been hospitalized psychiatrically—even once and even for a brief period of time, this has left an indelible [23] mark on them. They look at themselves as a person who was put into a "nuthouse", "place for crazy people". It does have a crippling effect on their sense of self-worth. In addition, there are other kinds of social sequela of institutionalization that we are probably all familiar with; at least in New York State, if one has been psychiatrically hospitalized, you can't drive a taxi without getting psychiatric clearance. Employers might ask "Have you ever been in a mental hospital?". Other members of the family will know this about the ex-patient. In fact, I think "ex-patient" is a poor term to use because the social role of being a mental patient I don't think can ever be discarded.

Q Can we necessarily equate mental hospitalization with psychiatric treatment?

A The two do not necessarily go hand in hand. There are some hospitals which offer fairly vigorous psychiatric

treatment programs. Very often, however, well, in some instances hospitals offer no more than custodial care. That was my impression today in our visit to the Walker Building. In other hospitals what is known as Behavior Modification Programs and familiar treatment is offered. While I won't go into the advantages and disadvantages of those forms of treatment, they are not the same as individual psychotherapy or individual psychotherapy in parent counseling, which in my mind is the single most important modality of treatment for emotional disorders of [24] childhood. It's terribly expensive in terms of professional time and that's why it's relatively rarely offered in institutional settings.

Q If, we are talking not in terms of the two boys in this case who have been hospitalized for over five years, but if we talk about children who are inappropriately put in a hospital for a short period of time, say for instance, a couple of months, does that alleviate some of the problems that you described or are there still detrimental effects that inappropriate hospitalization even for a short period of time?

A The longer the stay in the hospital, the greater the likelihood of what's commonly called institutionalization; that is, acceptance of the kind of routine and regimented life of an institution. However, if a child is in a hospital even for what in our eyes is a brief period of time, those effects can nevertheless be quite damaging for two reasons. One is the child's perception of time is quite different from an adult's perception of time, and a day or a week or a month in the life of a child from a developmental point of view as well as from their subjective point of view is quite different from that duration of time for any of us as adults. Secondly, the stigma, both public

and subjective of being in a psychiatric hospital, will be present whether one is in for a day or for a year or five years.

Q As a result of your analysis of institutionalization [25] hospitalization and its effects, do you have any opinion as to whether there ought to be a prior hearing as to whether a child needs hospitalization in non-emergency cases?

A I believe that such a prior hearing is definitely needed.

Q Could you explain why and what issues you think ought to be addressed at such a hearing?

A There are several issues that should be addressed. First, there should be an attempt to gather all the pertinent data from as wide a variety of sources as possible about the patient, family and entire situation. This would of course include the interviews with the parents and interviews with the child. Other kinds of data about the family should be requested—sometimes the family has some embarrassing information about itself, let's say a charge of child abuse, that it would not willingly share with an examining psychiatrist, but which a court, for example, might have the authority to bring in. I believe that in all such cases there should be an examination by an independent psychiatrist of the patient and I think of the parents too. I say independent in the sense of it being a psychiatrist who does not work for the same institution of the same system as does the psychiatrist who is recommending institutionalization and someone who examines the patient at a different point in time, because situations change rapidly and dramatically in child psychiatry and the flurry of excitement and con-[26]cern and panic of one week might look very different when the child or family is

examined the next week. So, firstly, much more thorough going . . . data gathering and integration . . . special tests, for example—that might be done, like psychological tests, then would be possible in a one shot psychiatric interview for hospital admission. Secondly, the wishes of both the parents and of the child should be told to the court. I think the recommendations of all of the mental health professionals who have examined the people in question. There should be a vigorous attempt to find the least drastic form of treatment; that is, the form of treatment that is effective and comprehensive on the one hand, but which least disrupts the natural life of the child as possible.

Q Do you have recommendations for say, an advocate for the child, and what effect would this have on the child to be represented at such a hearing?

A I think it's of great importance that the child have an advocate because psychiatric opinion while it's valuable, is not the only way to look at a given situation; that is, there are built in biases in the way psychiatrists and mental health professionals view data, and to have someone stand as the advocate for the child in such a hearing, I think, is quite necessary. I believe that the child would see this as a protection of his rights and would feel better that he is being dealt with fairly rather than in some, what might to his eyes, be arbitrary [27] and summarily fashion. For example, in the case of the youngsters I saw this morning, Joey and Jimmy, I believe that that kind of judicial hearing at the time of admission would have prevented both admissions, and it's clear to me from the reading of the data and I admit that I was not there five or six years ago, but from the data that I examined and which was available to the people at that time, was recorded by

them at that time, their hospitalization could have and should have been avoided. And in fact, the court might have played a constructive role in opening up possibilities for foster home placement or other special non-institutional child care placements which were not, in fact, available to the people involved at that time.

Q What is your extent of familiarity with the specific facts of the two boys who are plaintiffs in this case?

A I have studied the documents about them for approximately thirty minutes apiece and spoke with each of them for thirty to forty minutes this morning.

Q In other words, based on your professional opinion, after speaking to them and perusing their records, you feel that there is a very serious question as to whether or not they needed to be admitted in the first place and in fact, it is your decision that they should not have been admitted?

A It's my opinion that they should not have been admitted—let me try to spell that out. With Joey, the two diagnoses offered were hyperkinetic disorder and adjustment reaction of [28] childhood. Those are diagnoses . . . those are some of the more benign diagnoses used in child psychiatry. Most often, hospitalization is requested for psychotic reactions of childhood, like childhood schizophrenia. In my clinic, there are literally hundreds of children with those diagnoses being carried in outpatient treatment. Those are the garden variety diagnoses in child psychiatry. Nothing in those diagnoses points in the direction of hospitalization; in fact, quite the contrary. Secondly, the degree of impairment noted by the admitting psychiatrist for Joey was moderate, not even severe; so that if we consider this in the behavior dis-

order category, it was not even a severe behavior disorder. With Jimmy, he was felt to be borderline retarded and I believe had a diagnosis of adjustment reaction of childhood. The degree of impairment noted at the time of admission was mild, so I am quite surprised that hospitalization was recommended by the evaluating psychiatrist.

Q Would a delay in admission to a mental hospital pending a hearing in non-emergency cases be detrimental to a child?

A I would think that in almost all cases, it would be beneficial. As I said before, it is very hard to evaluate a situation accurately when it's a crisis situation, and that when the dust settles, one gets a much clearer and more thorough view of the situation. If a patient's behavior deteriorates so that their behavior truly becomes dangerous, then the parents could always return to the hospital to re-request admission.

Q As an emergency . . . ?

A As an emergency.

Q What effect do you think it would have on the child if he was ordered to have treatment as opposed to the present procedure whereby a physician checks on admission and makes the decision whether or not to admit him?

A If the child does not think that he should be hospitalized and is ordered to be hospitalized by the court, I assume that they will be unhappy about that decision. On the other hand, it at least does not make the hospital staff itself the culprit in the child's eyes to that decision, so that it might leave the hospital personnel more available to the child for the development of a therapeutic relationship. Also, I assume that most children would at lease see that they had their day in court and that the adults in his life acted in a judicious and deliberate and thoughtful manner about his future rather than hospitalizing him after a relatively brief examination and largely on the testimony of the parents.

Q Do you think it's therapeutically harmful to fail to place a child in an alternative setting to an institution when the child no longer requires institutional care?

A Yes.

Q Why is that?

A Because one wants to increase the child's adaptive capabilities. One wants the child to re-establish as soon as [30] possible ties to the family, friends, schools, other community groups, so that the longer one postpones this, the harder it makes it for the child to re-establish those ties. Childhood is a time of relatively rapid intellectual, social and emotional development. A delay is of greater importance in a rapidly developing personality than it would be in a relatively fully developed adult, who is more static in his psychological functioning.

Q Do you have any recommendations which could serve to prevent inappropriate continued hospitalization of children?

A I think there should be relatively frequent, periodic review by authorities other than those who are themselves responsible for the institutionalization of the child; of the continuing necessity of that institutionalization, and a vigorous attempt to find less drastic, more community based treatment possibilities.

Q Do you think a child would need an advocate in that kind of review?

A Yes, for two reasons—one as I said, I think the psychiatric viewpoint is not the only viewpoint which should be considered and secondly, one wants to have someone outside of the institution look into the situation because there's simply too much inertia in institutions and too much kind of self-servicing thinking. That's just true in all institutions, including the one that I work in and am a part of.

Q Specifically in relation to the two boys—Jimmy and Joey—what have you observed through your brief observation of their record and your interviews with them and the facilities in which they've been residing for the last several years as to their present state?

A My opinion is that both of these boys would be better served by less drastic measures than psychiatric hospitalization. My belief is that either a specialized foster home or perhaps a small group residence in the community could manage both of those youngsters. Their continued stay in a hospital setting is detrimental in terms of their emotional and social and intellectual development. I was especially concerned about the rather lifeless, passive self-effacing tendencies of Jimmy, who did not seem to be able to speak his mind or present his point of view and wishes in a forward and vigorous way. Joey is obviously clamoring for a home life and asks very explicitly to be taken care of in a family setting, as did Joey.

Q Jimmy?

A As did Jimmy—sorry.

Q Have you seen any other specific effects on the

children, for instance, those children, I believe, have been given drugs throughout their stay at the hospital. Through your observance of the children and your perusal of the records, do you think that that has had any effect on their development?

A I could only speak about that in general—I did not [32] look carefully at kinds and amounts of drugs. My understanding is that one child was on rather heavy doses of Ritalin—fifty milligrams per day—that's within acceptable range, but towards the upper boundary of acceptable range. And the other child was on Mellaril, which is a Phenothiazine drug. It's fair to say and I doubt that any psychiatrist would disagree, that there is increasing concern about the long term effects of medication, particularly when they are given over an extended period of time and particularly when they are given to children in adolescence because they are growing organisms. For example, Ritalin is a stimulant drug which at least in doses above twenty milligrams per day and one of our patients was getting in the neighborhood of fifty milligrams per day, has a growth retardation effect—a growth inhibiting effect—growth in terms of height and weight. It also causes a tachycardia; that is an increase in heart rate and in elevation of blood pressure. There are other dangerous side effects of Ritalin such as acute toxic psychotic reactions—those tend to be rare, and since they haven't happened, you know, with this child, they—it's not likely that we'll see it in the future. The point that I make is that one is always taking a calculated risk when one uses medication, and that there is increasing evidence that the stimulant drugs in children have long term consequences which were not anticipated. He also received Dextro Amphetamine, which is another kind of stimulant drug, which in all doses, [33] that is, there isn't a threshold

phenomenon—in all doses, has a growth retarding influence. Now with the Phenothiazine drugs, we've seen that, particularly for older patients who have been in state hospitals for many years, and those who are on heavier doses of these medications, that there can be rather serious crippling and irremediable effects. The syndrome that has received a lot of attention recently is called Tardivedyskinesia, which are involuntary, unsightly movements, which continue even when you discontinue the Phenothiazine medication.

Q Could you describe . . . you toured the facilities today at one of the state hospitals in Georgia, is that correct?

A At Central State Hospital.

Q About how long did that tour occur and what facilities did you see?

A It was approximately two hours, maybe an hour and a half, and I saw the children's unit, the adolescent's unit and the Walker Building. My summary of the tour was that I was favorably impressed by the children's unit, rather unhappy about the adolescent unit, at least its physical facility, and positively shocked that a seventeen year old person, no matter what her behavioral difficulties might be . . . was housed in the ward on the Walker Building which I saw.

Q Based on your professional opinion, could you describe what effect in terms of development of the children and adolescents, each of the wards that you saw, may have on the [34] individuals that are residing there?

A Obviously, the children's unit was built with many of the concerns which I have about hospitalization in mind, so that I would say that only the general growth

retarding effects of institutionalization; that is, some of the more subtle pressures toward conformity, toward rootenization, toward compliance, at least strike me in taking a look at the building. I did not get a detailed picture of the treatment program. In the adolescent unit, there was a kind of . . . it struck me as a mixture of . . . between barracks and a prison-like atmosphere. There was, in fact, wire netting, which apparently was installed at a time when senile patients were housed there. It was dormitory style sleeping arrangements. As we were leaving the facility, one youngster who was lying on the floor, and while that might happen, the staff is not responsible for the child lying on the floor, I was distressed that no one seemed on top of the situation to approach that patient and find out what the trouble was. Other youngsters admittedly a small number who had not been . . . who were not part of the group that was already at school . . . were sitting in front of the television set very apathetically and with no staff attention that I was aware of. Now I don't want to consider this a representative sample of staff behavior on that ward—I can only report what I saw. It was dismal, clean; the personnel seemed concerned and knowledgeable about, you know, their roles on the ward, but it truly was dreary. The [35] Walker Building was something else again. We did not see the seventeen year old young woman who was housed on that floor; she was off elsewhere, but we did see a number of women with the most overtly, bizarre, psychotic behavior, such that any lay person would know that he was in an insane asylum just as soon as the door opened up. And I don't understand why a seventeen year old person, no matter what their psychiatric problems might be, should be housed in such a center.

Q Did the psychologist in that ward describe to you

the behavioral problems of the seventeen year old?

A Yes, he did.

Q And . . .

A And they were in the nature of what sounded like rather serious behavior problems, but he said explicitly and I would feel it's internally . . . what he said was internally consistent . . . that she was not psychotic, that she was a severe management problem in terms of antisocial, obnoxious and sexual misbehavior.

Q What effect would buildings like the Walker Building and the adolescent's unit have on the development of the children and adolescents?

A I could only say for the Walker Building that it's disastrous. I don't know where to begin . . . I don't know how an adolescent, whether sick or well, could begin to cope in a constructive manner with living in close confinement with such [36] seriously disturbed and seriously regressed people. In terms of the adolescent building, I think that it's dreary and depressing and it seems to me to be countered to what should be the healthy aspects of adolescence.

Q And you said you were favorably impressed with the physical facilities of the children's building?

A I am.

Q Do physical facilities and a fairly active, responsive treatment staff alleviate the problems in the growth and development of the child when he does not need to be in a mental hospital?

A No.

Q Could you explain please?

A Yes. This is just a recapitulation of some of the things that I've said before—that to be in a mental hospital has a serious impact . . . serious influence . . . on one's own self-image. Joey and Jimmy will never forget these years. Secondly, they continue to be removed from any community involvement. I think we would all be in agreement that eventually they should be part of a community; that is, to go to a neighborhood school, albeit a special school, that they should live in a family, that they should belong to the Boy Scouts, or whatever else their fancy . . . wherever else their fancy lies, and that simply isn't being achieved in an institutional setting.

Q If your recommendations were implemented; that is, [37] either a prior hearing, a hearing prior to the commitment, in these boys' cases, or a periodic review to place them in an alternative environment after they've been committed, what effect would the implementation of those recommendations, do you think, would have had on the lives of these two boys?

A It would've been another story entirely. You're talking now about periodic review after institutionalization, and I want to remind you that I have very serious question about the initial decision to hospitalize these children, but if I pick up the story after they've been hospitalized, my belief is that with an outside, periodic review and a vigorous attempt with the authority of the court behind it to find alternative placement for such children, that it could have been found, should have been found and that much of the detrimental effect of the long-term hospitalization could have been prevented.

Q And it's your opinion that if they would have had a meaningful hearing prior to their commitment, they might

have never spent these last five or so years in a state hospital?

A Correct.

MR. GOREN: I have no more questions.

(BREAK IN QUESTIONING) (OFF THE RECORD DISCUSSION)

CROSS EXAMINATION

BY MS. KIRKLEY:

* * * * *

Q When a child is brought to you as a prospective patient, for out-patient treatment or in-patient treatment, do you view the child as a patient?

A Not necessarily, I view the child as the presumptive patient or the person whom the family views as the sick or deviant individual, but I feel it is my responsibility as a psychiatrist to look at the situation in depth to understand the interplaying forces between the child and the parents. More often than not, the situation is complex and there is an interplay between the needs, limitations and pathology of the child on the one hand and of the parents on the other hand.

Q Do you view it as your professional and ethical responsibility not to treat a child if he is not mentally ill?

A Could you restate that question?

Q Yes. Do you view it as your professional and ethical responsibility not to treat a child as a patient if you have diagnosed or evaluated him or her and decided that he is not mentally ill at all?

A I would yes with a certain qualification. If parents bring their child for psychiatric evaluation, there's some self-concern about that child—that can't be ignored; I

mean [41] to offhandedly say "Look, I think your child is normal, go home" I think would not really be offering the parents the kind of feedback they deserve.

Q For example, a parent brought a child in saying he needed a tonsillectomy—you would view it as your professional and ethical responsibility not to perform a tonsillectomy unless you thought he needed one, correct?

A Correct.

Q How does that differ in the practice of child psychiatry?

A It differs significantly in that the decision is a heck of a lot more complicated.

Q In what way?

A One is not viewing with tissue pathology that can be looked at, you know, with a speculum or under a microscope—one is looking at complex and delicate relationships between people.

Q But aren't there some psychiatric disorders that you can diagnose with more reliability than others, for example, organic brain syndrome?

A I would have to say that even the diagnosis of organic brain syndrome is not an easy matter. If a child . . . this is a technical point . . . if a child has a palsy that is a true muscle weakness or a difference in tendon reflexes, or a very obvious abnormality in the skull x-ray, or the electroencephalogram, one [42] might then, with some confidence, say that this is a child with organic brain syndrome. On the other hand, many of the evidences that are used by both neurologists and psychologists and psychiatrists for the diagnosis of organic brain syndrome are

behavorial rather than neurological kinds of evidence. So it's not always an open and shut matter.

Q But haven't recent studies over the past fifteen, twenty years, say, shown an improvement in the reliability of diagnoses at least for certain kinds of disorders, such as schizophrenia, organic brain syndrome?

A Definitely not.

Q You don't think that schizophrenia is now diagnosed with somewhat more reliability?

A No. I think it's as diffuse a concept as it ever was and the psychiatrists differ and disagree about it as much as they did fifteen years ago when I was in training. A personal experience that I have at the hospital where I work is that a few years ago, there was a psychiatrist researcher who was interested in manic depressive psychosis and the use of some of the newer drugs for manic depressive psychotics. They diagnosed manic depressive psychosis with a significant frequency on those wards. He then got a grant to go to another institution, same patient population going from the same catchment there, but without his particular interest in research investment in manic depressive psychosis—we have fewer manic depressive psychotics.

[43]

Q Are you familiar with Arthur Fallek's review of the classifications of schizophrenia?

A No.

Q You're not familiar with that at all?

A No.

Q And with his conclusions that it is diagnosed with about the same reliability as the need for a tonsillectomy?

A My friend, the need for tonsillectomy has undergone drastic revision as a child psychiatrist—it used to be done almost routinely in the 1940's—I was myself a victim of a tonsillectomy—it's rarely done now. Were these child patients that he was concerned about?

Q No.

A No. I could tell you that the very diagnosis of childhood schizophrenia is in question and William Goldfarb, who is probably the foremost researcher in the area of childhood—I don't know what to call it—schizophrenia or psychosis—recently changed his mind and after publishing a book called *Childhood Schizophrenia* now prefers to call the same behavior "childhood psychosis". And schizophrenia in childhood is a very different disorder than schizophrenia in adulthood.

Q You referred to behavior in families known as scapegoating?

A Yes.

Q How prevalent do you think this is?

[44]

A Well, I think it applies to one of the youngsters that we . . . I think it applies to Joey, who is one of the two clients we are concerned about. The story of Joey, and I think there is no one who is blameworthy, I don't think there is any villain in this piece . . . the story of Joey as I understand it, as I understand it from the record, is that essentially he had to be expelled from the family in order for his adoptive mother to successfully continue her second marriage; that the boy's behavior was such that it was intolerable for her second husband, and that there was a conflict within her as to which person she was going to relate to more intensively and she decided, I'm sure

after much soul searching, that Joey simply could not continue to live in the family. And I think he was, in a sense, sacrificed in order for that marriage to be preserved. It's rarely seen in that kind of clarity, but it happens in more subtle fashion frequently and I think we might even in our personal experience know marriages that seem to hold together as long as there's a child who is seen as sick, disturbed or deviant.

Q On what do you base the opinion that Joey was "scapegoated"?

A "Scapegoated" in a sense that he was sacrificed in order to preserve her second marriage; that it was necessary for him to be removed from the home in order for her to continue living with the man that she married.

[45]

Q I want to know where you got that from?

A From these documents, particularly from the report of the social worker who was working with the family prior to Joey's admission to the hospital and who felt that that admission was inappropriate.

Q You are not, are you, Doctor, referring to anything in these notes—you are referring to an affidavit?

A No, I am referring to something in these notes (examining notes). Oh no, I am sorry—I am referring to an affidavit from a woman social worker.

Q Do you know when the affidavit was signed?

A If it's not here, it's in the car. No, offhand, no. I would be happy to look for similar data here (examining papers).

(OFF THE RECORD)

A Let me read from the affidavit of Janet Scott, which is dated the eighteenth of November, 1975.

Q Well, that's already in the record; I just wanted to clarify that that was what you were basing your opinion on rather than the admission papers you have before you.

A If you give me a minute, I would like to look at those because I think that the information was consistent.

Q Sure.

(Dr. Messinger examines papers)

A Yes, I am reading from the summary progress note June, 1975—Ray Joey Master Lister.

[46]

> "This is shortly after admission the family tried to cooperate with family therapy. Mr. Sherma, even though apparently motivated at first, became discouraged with Joey's cyclic behavior and no consistent improvement. Mrs. Sherma was threatened by the process of really changing the situation. She felt a lot of guilt about Joey's condition. She really cared for Joey and it was a painful, traumatic decision to give him up. It is to her credit that she dealt with her feelings of helplessness and hopelessness Joey created for her in the hope he could be put in a successful foster home. Her own marriage was threatened by Joey's disruptive behavior in the home and this was the only course for her own natural child's welfare."

Q Do you know what happened when Joey went home on leave and visited Mr. and Mrs. Sherma with the new baby in the household?

A I know that it did not work out; the intimate details of that I don't know.

Q Are you familiar with Georgia's mental health program in 1970?

A No.

Q Are you familiar with the availability of foster homes or group homes in 1970?

A No.

Q Other than your reference to Joey's case as one of [47] possible scapegoating, could you say how prevalent scapegoating is in regards to admissions of children to Georgia's mental health hospitals?

A With reference to Georgia's mental health . . . ?

Q Yes—the seven regional hospitals.

A Hospitals . . . no, of course I can't.

Q Do you have a percentage figure for your own hospital?

A I'm not pretending that these mechanisms are so obvious that they're easily countable. I can say that in . . . and neither have I done a particular study of this mechanism . . . I could say that in a goodly percentage of cases, it is to the advantage of the parents, and not necessarily in a selfish point of view, it is to the advantage of the parent to extrude a child from the family that hospitalization is a particularly desirable way to extrude a child from the family in some senses, because it can be seen by the parent as well as by the professionals who are hospitalizing the child as a therapeutic manuever.

Q But it is in many cases precisely a therapeutic manuever, is it not? It is therapeutic for some children to be placed in hospitals?

A It is therapeutic for some children to be placed in hospitals, but the question is how to distinguish the sheep from the goats and what kind of procedural safeguards

should be built into the system in making those kinds of distinctions and whether [48] other treatment approaches might better address the family and community roots of some of the psychiatric disturbances that we are concerned about.

Q Do you think that you are able to tell the sheep from the goats?

A After considerable study of a child and family, information from school, other treatment agencies, I can offer, I think, a reasonable recommendation to parents and children about whether hospitalization is needed.

Q Do you think your process of evaluation and recommendation would be improved by requiring that the parents file a petition with the Juvenile Court?

A Yes, it would.

Q In what way?

A Because I look at these matters almost exclusively from a psychiatric perspective—there might be information that parents would be unwilling to share with me, but which the court might be privy to—I would be happy to have any additional information provided by other sources and I would be delighted to have an effort made to find placement or treatment modalities which I might not be aware of or which I might not have the key to unlock.

Q In Georgia, a parent could file a petition in Juvenile Court alleging that his child is mentally ill—is it the same in New York?

[49]

A A patient can . . . I'm sorry . . . A parent can file what's known as a Pens Petition that the child is a person in need of supervision.

Q But that relates to unruly or ungovernable conduct?

That's correct.

Q But not mental illness as defined usually in the health codes?

A They tend to overlap, but I understand your distinction.

Q So you know of no specific process whereby a child can be declared simply mentally ill by the court as opposed to a person in need of supervision in New York?

A Correct.

Q If there was such a judicial procedure available, then would it not be possible in cases where you have professional doubt for you to ask the parents to file such a petition rather than requiring that a petition be filed on every case?

A Please restate the question.

Q I presume from what you are saying about the values of the judicial procedure, one of the values would be the subpoena power to gain additional information; another value, according to your statement, would be the value of the court having other resources in which to place the child?

A Yes.

Q Couldn't you look at that procedure as an option; [50] you are not saying that in every case your professional judgment needs to be circumscribed by judicial procedures, but that in some cases, judicial process might be helpful?

A I believe that hospitalization is such a drastic and possibly damaging experience for a child that in all cases

except for obvious emergencies, that it is . . . that it should be mandatory . . . that the matter be previewed by a judicial body.

Q Even if you were positive professionally that you were making a correct recommendation and had no questions about the validity of your case history?

A Correct—I'm not infallible.

Q What would you describe as an emergency situation?

A An emergency would be a situation in which there has been behavior or there is imminent danger; tangible, demonstrable evidence of imminent danger to self or others.

Q You did say though, that even in non-emergency situations, the family viewed it as a crisis, is that correct?

A Often.

Q Most of the time or often?

A Most families ask for hospitalization of their child when there is a crisis in the family or at least when they view behavior as being a crisis, yes.

Q Don't most of them view hospitalization as a last resort for the child?

A Not necessarily . . . parents are not as knowledgeable as [51] perhaps we are in this room about the range of treatments available . . . that's particularly true of less well educated parents. Sometimes, as in my community, the hospital is virtually the only health facility around. They don't have the money to go to a private psychiatrist.

Q But isn't it the role of the admissions unit staff to advise the parents on what other options are available?

A It should be, but as institutions . . . it should be; however, first, there aren't, at least in the particular catchment area I work, very many other options available. Secondly, if one is working in a facility on an emergency service and there are empty beds on that efficient service, there's a tremendous tendency, tremendous human tendency, to hospitalize that child if in doubt.

Q Why is that?

A Because one becomes . . . I don't know what the word is . . . habitualized, socialized to using that means to resolve the difficulties at hand, and because it might be more time-consuming and difficult to try to work out things with a school, for example. Oftentimes, these crises arise in the school setting. Because psychiatrists rarely get up and move out of their office or out of their hospital to visit a classroom or speak to a school principal, and because many psychiatrists are either not trained to or not as comfortable in operating in a community psychiatry framework as opposed to a . . . hospital framework.

[52]

Q This judgment is based primarily on your experience in New York in Metropolitan Hospital?

A It's based primarily on my experience in New York, not necessarily at Metropolitan Hospital, but from my speaking with colleagues, observing the behavior of other professionals, and reading of the literature.

Q Is that phenomenon, that is, admitting to an empty bed, any different in a private hospital and a public hospital?

A I can't answer that question for sure because I haven't worked in a private hospital myself. I think the pressures there might be different and financial considera-

tions might become paramount . . . not paramount, but contributory to the decision.

Q That the profit . . .

A The profit motive might enter into . . .

Q Might enter into the decision.

A Yes. In a public hospital, there are also considerations about census; that is, if the census of a facility falls too low, it's likely to be closed, or a person known to be transferred, and there's sometimes an effort by the people in charge of that unit to maintain it simply because that's their territory for work and that's their job line at stake.

Q Are you familiar with the techniques we are using in Georgia to avoid that?

A No, I'd be happy if you have some. I'm sure it's [53] a problem you have wrestled with.

Q Are you familiar with Daniel Offer's work "The Psychological World of the Teenager"?

A No, I'm not.

Q You're not familiar with the article at all?

A No.

Q Then you're not familiar with his conclusion that you can distinguish between normality and psychopathology in adolescents?

A I'm not saying that one can't make judgments about normalities, psychopathology in adolescents; I'm called upon to do that every day of the week. I want to introduce a note of skepticism about the exactitude of that decision, and more importantly I'm concerned about the process by which that decision making is made; that is, I'm con-

cerned about when, where, by whom and with kinds of safeguards that decision is made. And I feel that it's too . . . that the deci . . . you know, decisions about psychopathology if you want to put a child into out-patient group treatment versus out-patient individual psychotherapy, we don't want any judicial hearing about that, but when you take the radical step of removing a child from the family and institutionalizing them in a psychiatric facility, I then do want that decision reviewed by an independent body. And I want it to be reviewed before it happens rather than after. And I would hope that the judge would listen very [54] carefully to the evaluating psychiatrist or psychiatrists; and that information should be respected.

Q Are you familiar with court commitments in New York? Have you treated children who have been committed by the courts?

A I have very little first hand experience with court commitments.

Q So you wouldn't have any opinion about whether or not, in your judgment as a psychiatrist, courts are committing inappropriately?

A My understanding is sometimes those hearings are anything but exhaustive reviews of the situation, so I am not talking about a superficial, rather state kind of judicial review; I'm talking about a serious investigation of the situation and collaboration of professionals with counselors, etc.

Q I had started out asking a series of questions asking about diagnosis in adolescents, and I think one portion of your testimony was that it was particulary difficult to diagnose an adolescent?

A Correct.

Q Would you state again the basis of that opinion?

A First of all, it's a widely held opinion. Adolescence is a time of turmoil, of anxiety, of depression, of mood swings, of extreme behavior fluctuation. Now these aspects of behavior often enter into a diagnosis of psychopathology in an adult. If there are rapid mood swings in a thirty-five year [55] old person, we use that as evidence of psychopathology. We couldn't do that . . . we shouldn't necessarily do that with a youngster of fifteen. Also, the diagnostic categories in adolescence are much less well defined and there's even less general acceptance of which categories under who falls than in adult psychopathology. Whatever problems there might be in the classification of adult psychopathology, they are much greater in adolescents and children. That's a fact.

Q What studies or other psychiatrists do you rely on in particular—you say it is widely known?

A I would say that's something that I have heard from my teachers and supervisors, from my colleagues, that I have read in the literature.

Q Nothing specific you could mention four or five articles or four or five books?

A I will cite you some material from the literature. As I said earlier, this manual relates to the diagnostic and physical manual abilities of the American Psychiatric Association is one way of approaching psychopathology in adolescents. An expert group, an expert committe of the Group for the Advancement of Psychiatry, which enjoys an excellent reputation in American psychiatry, sat down and came up with a radically different set of classifications of childhood and adolescent disorders. It seems to

me that the tremendous variance between these two groups speaks a fundamen-[56]tal lack of unanimity. Let me think for a moment. I have been reading the literature recently about the diagnosis of such because I have to speak at a Grand Round Presentation in December; I have failed to come up with any good articles on the subject, and I think that speaks of the difficulties, the imminent difficulties in this area rather than any shortcomings in the psychiatrists in this area.

Q What do you view as—I know this is a very general question—as the parents' responsibility in raising a normal child?

A Could you try to be more specific?

Q In the popular literature now, it is the general trend to think that parents ought to take the lead in prescribing, scheduling doctor's appointments, necessary care and training—that parents need to set the requirements—this is what is needed to develop a good basis for the child to grow up comfortable in his own mind. I'm just asking you if you agree with that issue?

A I would say that that is a question of value and that if I responded to that question, it would be more as a father than as a child psychiatrist. There is a legitimate difference of opinions; I think too much depends on issues involved. I won't have a discussion with a child about an appendicitis. I would and I do have discussions with my children about which after-school activities they are interest-[57]ed in. It also depends very much on the child's individual personality.

Q But you wouldn't have a discussion with them about necessary shots, regular doctor visits, regardless of how the child felt about these things, regardless of the child's wishes?

A Not when it concerned straight medical care.

Q As I understand your testimony in regard to psychiatric hospitalization, you're not saying that the child should not be compelled against his will to go into a hospital, but that the hospitalization should be a last resort and should be based on judicial process?

A Correct.

Q Is it your opinion that the standards for involuntarily hospitalizing a child should be the same as involuntary hospitalization of an adult?

A You would first have to tell me what they are.

Q In Georgia for an adult, he has to be mentally ill and either dangerous to himself or others or incapable of taking care of himself.

A Well, the last part—that couldn't apply to a child, because a child is relatively dependent, but otherwise, I would agree that the same standards should hold . . . that is of danger and mental illness.

Q But not only of danger—in other words, Georgia [58] has a stipulation for involuntary hospitalization for a person who is mentally ill and in need of treatment.

A I agree with Georgia's position.

Q For a child of five, wouldn't you say that he should be mentally ill and in need of treatment in a hospital as a last resort, but not required above and beyond that that he be dangerous to himself or others?

A Could you rephrase that?

Q Then you are advocating that a child be hospitalized if he is mentally ill and in need of treatment, is that correct?

A This, I see, is a somewhat separate issue from before. I would say that the forced hospitalization of a child and I think it's especially true in adolescents, should be only in cases where there is mental illness and dangerousness.

Q What about adolescents?

A In the case of an adolescent and a child.

Q In a child no matter what his age?

A The answer would have to be affirmative.

Q Do you think that it's important that mental illness be treated early?

A Yes.

Q Why?

A I believe that, particularly for children, since [59] they are developing organisms, one wants to maximize their possibilities of adaptive behavior.

Q Do you believe that they should be treated even when they are not dangerous to themselves or others?

A That's a sticky matter in child psychiatry because relatively few children seek psychiatric help on their own—they are nearly always brought by the parents—and it is one of the dilemnas facing the child psychiatrist because he then has to enlist the alliance of the child; but quite honestly, if an adolescent is brought to me with a condition other than one which makes for dangerousness to himself or others, and he is dead set against treatment, I try to respect their wishes and to leave the door open for further contact in the future and I have found that the adolescent respects the fact that I respect their wishes, and at least on occasion, I have some come back at a future time.

Q Let's take children and then adolescents, by which I mean up to thirteen for the child. Do you think that a twelve year old has a capacity to make an informed judgment about whether or not he should be treated?

A Treated in what way?

Q Treated—that he is mentally ill and that he then has the informed capacity to decide whether or not to be treated by a psychiatrist, either as an out-patient or in a hospital.

[60]

A If we are dealing with a twelve year old, then I think we are dealing with a very . . . that's the gray area in my own thinking, so if you don't mind, let's take either an eight or a fifteen year old—that might at least clarify in issues. It depends on the terms in which it's put, and that's the whole business of child psychiatry—how to communicate with a child in terms that are meaningful to him . . . terms of his vocabulary, cognitive understanding and emotional understanding of the situation; and I think that it is possible to talk with children as young as eight in a way that really keys in to their perceptions and feelings about the situation in which they live, so that treatment can be presented to them in a way that's meaningful to them and which they might see as beneficial.

Q Now suppose an eight year old said "I'm not going to Dr. Messinger's office at all"?

A I would certainly want to discuss that with the child himself to understand where he's coming from. I would certainly want to discuss the situation further with the parents and well, actually . . . it has actually never come down to that in my own practice. I think it would depend on the seriousness of the problem at hand and if I

felt that the problem was quite serious, I would insist—I would say to the parents that they should use their authority to bring the child in and I would explain to the child that whether he liked it or not, we as adults saw this as a grave situation and that perhaps he didn't [61] understand it now, but we assumed that he would eventually understand our action.

Q Okay—now let's take a fifteen year old.

A With the fifteen year old, my tendency would be to give them discretion short of emergency kinds of behavior; that is directly self-injurious or homicidal behavior.

Q Starting at fifteen or is that just where you are sure of your opinion?

A I'm afraid that since we are dealing with the developing child and children who develop at different rates that, much as I understand your interest in coming up with a specific chronological age, I cannot do it. My overall tendency would be to enlist the patient as an ally in the exploration of his problems and whenever possible, to grant him or her the respect of deciding whether or not they are in need of counseling or treatment.

Q With the fifteen year old, should the parents use their authority to at least get him into the office?

A I have no objections to this. Parents have a right to make their wishes known too.

Q But with a fifteen year old, I guess we'll just take an average fifteen year old in intelligence, you are saying that the particular problem in diagnosing is there, because of the turbulence in adolescence and rebelliousness of adolescents?

[62]

A Yes.

Q Don't those factors mitigate against a fifteen year old being able to make an informed judgment?

A In some ways, yes; in some ways I think adolescents are particularly perceptive about themselves and adults often have a hard time understanding and empathizing with adolescents, including the psychiatrist.

Q Would you use this standard on an individual basis as to whether or not a particular adolescent should be able to reject treatment, rather than drawing a chronological age at which one should be able to reject?

A I'm able to . . . I mean I'm not, you know, in the legal profession, so I'm not able to use that kind of . . . I have that kind of latitude, yes.

Q For any patient up to eighteen, you use latitude in deciding which one can make an informed judgment about treatment, and which one cannot?

A Again, are we talking now about out-patient treatment or in-patient treatment, because I make a firm distinction between those two.

Q Okay, let's take out-patient treatment.

A In fact, I think that patients, whether kids or adolescents, but certainly by eleven or twelve years of age, children vote with their feet—that is, a twelve year old who doesn't want to come in to see the psychiatrist ain't [63] coming, you know, he stays at school, he can't be found, he doesn't talk—I've lived through many sessions in which twelve year olds don't say a word—they make their will known. So we can say, you know, here in this room, that they should be forced, parents should use

their authority to have the child engage in treatment, but one can't, in fact, force the issue.

Q We were going back to adolescents, and you were saying that you saw a distinction between whether or not a child or an adolescent should be forced to have out-patient treatment or forced to have hospitalization.

A I would not want to force any adolescent to have out-patient treatment.

Q From thirteen to eighteen?

A Correct.

Q And what about hospitalization?

A I think the judicial safeguards that we've been talking about should be operative.

Q Using a standard of dangerous?

A That happens to be my personal opinion, but I could see others arguing that mental illness and a need for hospitalization should be the standard and I wouldn't, you know, I wouldn't move out that as another option.

Q You've expressed a preference for psychotherapy by a psychiatrist?

[64]

A For those children who are sick enough to be in a hospital, I think they also deserve direct treatment by a psychiatrist, preferably a child trained psychiatrist.

Q But doesn't a team approach by a unit in the hospital give more pervasive treatment at all hours of the day?

A I like the team approach; I don't think that these two are incompatible, but I think that hospitalization

should be reserved for the sickest kids and I think the sickest kids deserve treatment by the mental health professionals who are trained to deal with the sickest kids and those are psychiatrists.

Q You've talked about the effects on a person's self image from hospitalization?

A Correct.

Q Are you familiar with this article by Goven Fain—"The Stigma of Mental Hospitalization"?

A No.

Q Are you familiar with this article by John Cumming and Elaine Cumming on the stigma of mental illness?

A No.

Q On what do you base your opinions?

A Largely on clinical experience.

Q Your personal clinical experience?

A Correct . . . some of my testimony about the injurious effects of institutionalization I think can be corroborated by [65] the experiences of Joey and Jimmy. One of the things that I noticed about Joey is that he was—he latched onto whoever seemed to offer him what I would call a feeding experience, a nurturing experience, giving experience, at that moment. Now I can't make an ironclad case that's the result of his institutionalization, but I'm sure that it is; that is, in an institutional setting because one doesn't have the mother and father to whom one can rely on for nurturance over an extended, really indefinite period of time, one has to make use of whoever is available at the moment. Also, one learns that the good guy or the good woman who might be available today

might not be available on the next shift or might not be available the next week or month, so one takes what one can when one can. I saw a great deal of that mentality in Joey. What I saw with Jimmy was, I think, an apathy and listlessness that's another kind of adaptation to institutional life; that is, one gives up—one gives up asking, because one's needs have not been met on so many occasions. I think that's in fact more serious in its consequences than Joey's gobbling up whatever comes his way and making known in no uncertain terms that he wants more more more.

Q But isn't what you're saying, really, that these two twelve year old boys need a set of loving parents who can cope with their behavior?

A Yes, but they don't; so the question becomes what [66] can we, as the adult community, offer them in lieu of that? And it seems to me that a foster care setting would much more nearly approximate the kind of continuous, reliable parental care than would even the best of institutional centers.

Q Let's go, though, beyond that, another aspect was the question of stigma, not what happened to them in the hospital, but how they felt about it and how other people felt about it after they got out? I think I could fairly summarize the study of Goven Fain on a follow-up of patients from a mental health hospital—that the patients felt like their life had improved after hospitalization and that in significant areas—work, home life, relationships with others—they saw an improvement in themselves—do you disagree?

A Certainly there are patients who, in fact, do improve in hospitals and I recommend hospitalization to

some patients. I would ask, though, whether these were patients who were hospitalized as children, whether they spent five or ten years in hospitals, and whether they themselves sought out the hospitalization or were put in by other people who "volunteered" them . . . I think those are important variables.

Q Isn't the type of hospital also important—whether or not they've had significant relationships with their home community while they were in the hospital, whether they've been out on convalescent leave?

A To some extent, it is.

[67]

Q So there are really many variables in how hospitalization can affect a person?

A To a degree, there are many variables. I can add that these two youngsters are very desirous to leave the hospital.

Q Let's turn now to the procedures which you've been proposing.

A Yes.

Q From your discussion of the problems of diagnosis in inter-related pathologies of the parent and child, I take it that you view the dynamics of the situation when a family presents a child as a problem to you as being a very delicate one, that there are some delicate human relationships that are involved, that you, as a psychiatrist, try to understand what's going on behind the facade that people present to you?

A Yes, and not to pre-judge who is the patient; that is, not to take at face value the judgment made by the

parents that the child is the one with the problem—it might, in fact be true, more often than not, it is more complicated.

Q What kinds of questions do you ask to find that out or what do you do?

A It takes a few years training to learn that—I don't mean to treat your question lightly—what do I do. I try to establish a tone that allows for people to speak forthrightly about each other and about themselves. I try to give [68] them time in which to do that. I try to establish a spirit that no one is at fault. I try to give people the benefit of the doubt and to credit them for the positive that they bring to the situation. I try to understand the way that they could see the situation. I try to offer suggestions that might be usable and might be acceptable to them within their own cultural framework, their own degree of sophistication; and I guess, in general, I try to establish a climate in which, as a group of people in trouble, they can take a look at what's going on and take positive steps to correct them.

Q How many Pens hearings have you attended in New York?

A I can't in all honesty say that I've attended; I might have one or two . . . I don't . . . they just don't come to mind.

Q How about delinquency proceedings?

A In New York, let's see . . . then the answer is no—none.

Q Any commitment proceedings for children that you have attended?

A Commitment proceedings for children I don't think I have—for adults a handful.

Q Well, that's not the best basis for this question, but let's proceed on that basis, then. Do you think that the proceedings you have observed in any way simulate the process which you feel is necessary to discover what's going on in a [69] family group?

A Well, I'm really not in a position to answer that because the adult commitment proceedings, the family as the locus of concern was . . . the family was not the locus of concern, but the offering of data as objective as possible to a judicial third party . . . that I thought was worthwhile; that is, that one had to establish in a factual way and use nontechnical terms what was going on. Psychiatrists tend to use catch words that are meaningful to them, but which might or might not be well-established in fact.

Q But the process that you've described is patient sensitive individualized for that particular group—it would not be a matter of, you know, a 10:00 A.M. hearing set for Mr. and Mrs. John Jones versus Johnny Jones—petition alleging that Johnny Jones is mentally ill?

A I would hope that if at the end of this patient kind of exploration of the situation which I did in my office that I concluded that hospitalization for Johnny Jones was my recommendation—that I could then present that data to a court—I'm not saying that that data collection has to take place in a court setting—I don't think that . . . makes sense.

Q But then all of this that you have worked so hard and in such a careful manner to elicit will just simply all have to come out at 10:00 A.M. in the morning, accusations and cross-accusations among the family members, all to prove that [70] Johnny Jones is mentally ill?

A Well, if by ten in the morning you mean that it would be given short trift, I hope not.

Q I don't mean necessarily short trift, but that courts have calendars and they do things by calendars and that a hearing would be set, all the parties would have to be there, and it would proceed in that fashion—an examination, a cross-examination by lawyers, not by psychiatrists.

A That's right.

Q But you have never attended a hearing of that sort?

A In the commitment hearings that I have been a part of, yes, I was cross-examined.

Q No, but I mean where it was the commitment of a child.

A No, I haven't.

* * * * *

DIRECT EXAMINATION

BY MR. GOREN:

Q I just want one last thing, Doctor. In making a decision to hospitalize a child, is it important that the physician who is evaluating the child in regards to the necessity for admission be able to converse fluently in the same language that the child converses in?

A Yes, and I would add to that if at all possible, be familiar with the cultural background of the child.

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[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

[1] (Caption omitted in printing)

Deposition of DOCTOR DOUGLAS SKELTON, taken on the 3rd day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
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EXAMINATION BY MR. GOREN:

* * * * *

Q Do these physicians who make the decision to admit somebody to a hospital, have any kind of special training in making decisions whether or not to admit? Does your department give admitting physicians special training in making these kinds of decisions?

A In general the answer to that is no, that that special training comes through their own training and experience and those kinds of experiences that qualify them for licensure to practice medicine and surgery in this state.

Q Okay. Do any of these policies or regulations describe in detail what needs to be done before someone is admitted to the hospital, for instance interviews?

A No, they do not.

Q Do they describe what sources need to be contacted before you admit somebody, what kinds of information need to be received before a decision is made?

A They do not describe that, and if I could I'd like to describe why they do not. They do not because the act of admission is an act of medical practice, and the basis of that physician's training and experience in terms of obtaining their M.D. degree, their training, for example, in an improved training program [9] for psychiatry, for example, would include those kinds of—that kind of information that should be obtained in the clinical interview with the patient, what kind of information from other sources ought to be important in terms of that admission decision. So it would be my view that to promulgate rules and regulations for that would be an attempt on the part of me as an administrator in this sense, to practice medicine through other physicians who are duly licensed to practice in the state, and are duly responsible for their decisions.

Q So, because of that there are no written—written policies or regulations specifying what the admitting physicians need to do before admission?

A No, except in the sense that I mentioned earlier, that there are instructions clarifying what they law is in terms of admission.

Q Are there any standards in terms of diagnoses that physicians—admitting physicians in the regional hospitals use to refer to a particular condition of the patient that they're evaluating?

A I'm not sure what you mean by that question.

Q Is there a set of standards, a set of diagnoses, that admitting physicians generally refer to in diagnosing an individual's condition?

A They generally refer to diagnostic categories listed in the Diagnostic and Statistical Manual . . .

Q Okay. And that comes out in different editions?

A Well, there has been—the last one was called the Diagnostic and Statistical Manual Two . . .

Q Uh-huh.

A . . . which was an up-date of a previous publication which made [10] some changes in the diagnostic criteria classifications.

Q Do you know specifically what procedures admitting physicians use, what—what set things they may use in evaluating somebody prior to admission?

A My assumption is they approach it through an evaluation of what the presenting problem is, what the history of that presenting problem is, what the family

history is, what the social history is, what the history is of previous medical or psychiatric treatment, what the mental status exam conducted at the time would show, what reports would show from community agencies involved with this person in terms of either social or health needs in the community, and would supplement that with interviews or evaluations of significant others that would accompany the patient, either family members or concerned employees, or sometimes sheriffs, for example, would bring somebody in.

Q This is an assumption on your part, and an assumption based on what you assume they would have learned in their medical training and an assumption based on the fact of what they would do—what you think they would do individually, but not pursuant to any standards that the division has promulgated, is that right?

A That's essentially correct, although that assumption is made on a little more than that. It's made on the basis of my own experience at the Georgia Mental Health Institute and my awareness of what kind of practice is followed by the physicians there in terms of admissions, and general discussions I've had with other superintendents about these issues when they would come up in context of some kind of problem that we were addressing, and a general awareness that I have in terms of our [11] —our desire to develop a unified service system, which means involving the hospital and the communities together, so that we have urged that there be involvement between hospital staff and community mental health and mental retardation staff in terms of decisions to admit, so I'm aware of that general kind of push from my office level and through my staff over the hospitals and community programs. In terms of my direct experience has

been through the Georgia Mental Health Institute, that experience in the past.

Q And there are seven other regional hospitals in the state?

A That's correct.

Q Okay. You don't know specifically, for instance, how long an admitting physician in one of the regional hospitals would take to do an initial interview of a prospective patient prior to admission?

A No, I do not know, and I would—I would think that varies in terms of the nature of the problems and the difficulty in obtaining the interview—the material that's necessary to make a decision. I do know, for example, that the regional hospitals at Augusta and Savannah, as well as the Georgia Mental Health Insitute, are accredited by the Joint Commission on Accreditation of Hospitals, and they're—the things that they check the hospitals against would involve the kind of involvement between hospitals and community agencies in terms of that evaluation procedure, if there is sufficient documentation on the record to justify the diagnoses and treatment plan, or the actions that were taken.

Q And the remaining hospitals are not accredited?

[12]

A The remaining hospitals are not accredited by the Joint Commission, that's correct.

Q Have you or has your division promulgated any written regulations concerning informing voluntary patients of their legal rights?

A Informing voluntary patients of their legal rights?

Q Yes.

A That would be covered in the general material that I referred to earlier, which breaks down the requirements of chapter 88-4 and 83-5 of the Georgia Health Code in terms of what kind of forms, procedures, etcetera, must be followed for voluntary and involuntary patients according to either medical or judicial commitment laws, depending on which the county should select.

Q And these have been distributed to all of the regional hospitals?

A That's correct. All the regional hospitals, all the judges of Probate Court, all the district health officers, and the mental health mental retardation directors.

Q And what do these regulations say in terms of the actual informing of the patients of their rights, how is this done?

A Without looking at that statute I'm not sure I'm answering accurately, but I believe there is a notification given that has a certain mental health number that states your rights as a voluntary patient in Georgia's mental health facilities.

Q Are you saying the patient is given a form?

A Yes.

Q Do you know—do these regulations that you talk about provide that the forms be orally read and explained to the patient?

A My understanding of the requirements of law would indicate where the form cannot be understood that it be explained, where there's [13] some effort—some evidence to indicate that it cannot be understood, that it be explained.

Q Is there a notice given for a patient's right to file for a writ of habeas corpus?

A The notification of right to file for writ of habeas corpus is a part of the involuntary commitment procedure, that notice is given.

Q It's given to involuntary patients, it would not be given to voluntary patients?

A To my awareness it's not given to voluntary patients. They're not being held against their will. I don't know why they'd file a writ of habeas corpus to be released.

Q In your experience has there—have you ever seen a circumstance where a person is—who is labeled as a voluntary patient admitted to a hospital when he didn't want to be there?

A Well, I've seen, in the treatment of mentally ill and emotional disordered the same thing that you see in society in general, that voluntary acts have degrees of voluntariness in them. There may be certain coercion involved in—for example, the alcoholic, whose wife is threatening to leave him and take his kids if he doesn't avail himself of the treatment opportunity on the voluntary basis. He may feel somewhat coerced by that, but at least he's not coerced by me and the doctors. At least, I don't believe he is. I would say there would be degrees involved in how voluntary a person felt, depending on what pressures were put on him to seek treatment.

Q Is it possible to have a child or an adolescent come in to a mental institution under section 88-503.1, the voluntary [14] admissions statute, who didn't want to be there, and it's possible they could express that need, and yet they would still be admitted as a voluntary patient?

A That's correct. They would be admitted on the basis of the evaluation of the physician, that hospital care was indicated, and on the basis of the signature of their parent or legal guardian indicating that admission.

Q Okay. And are these children also given that form of their notice of their rights as voluntary patients?

A That right—that notice of right is given to whoever signs as the legal person responsible for their entry into the system voluntarily. So if it was a parent that signed the voluntary admission form it would be the parent that would have the right to indicate the desire for discharge within five days.

Q So you are saying that this form would not be given to the child, the child would not be notified of his rights to discharge as a voluntary patient?

A To my knowledge the child is not informed of it.

* * * * *

[16]

Q Can a child file a request like that?

A A parent or guardian would have to file the request for the child.

Q The child couldn't file it on his own?

A The parent or guardian is acting as a legal person in signing the voluntary admission. The parent or guardian would be notified of the right to request release.

Q Okay. Again, the child couldn't do it on his own?

A That's correct.

Q It would have to be his parent or guardian?

A That's correct.

Q The same parent or guardian who admitted him or applied to have him admitted to the hospital?

A That's correct.

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[44]

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EXAMINATION BY MS. KIRKLEY:

Q Would you identify Exhibit One, please, Doctor Skelton?

A A copy of my resume.

Q Okay. And is there anything that you would like to add to that?

A There are only two things that are not on here. I am presently a clinical professor of psychiatry at Emory University, and an examiner for the American Board of Psychiatry and Neurology.

Q Okay. Would you describe, please, the roles and duties of a [45] hospital superintendent?

A The hospital superintendent has general administrative and programmatic responsibility for the hospital services. In instances where that superintendent is nonmedical, there is a Chief Medical Officer or a Clinical Director or a Chief of Staff, referred to in a number of different terms, who would be the highest medical authority within that—within that hospital answering to the superintendent, then, for the quality of medical care in the hospital. The responsibility then involves the treatment programs through the superintendent or the chief of the medical staff, and the medical staff, there are a series of committees or responsibilities in terms of the adequacy of medical care. For example, there have to be

medical staff meetings periodically, there is required attendance of physicians, a certain percent. They—they lose their jobs if they do not attend on a regular basis. They are required to review certain records in terms of adequacy of care. They have . . . committees that address what medications are used within that institution. Medical records, procedures are also reviewed by that type of committee.

Q Would they be the individuals to establish policy with regard to admission procedures and periodic utilization reviews?

A Yes, those would be established through the superintendent's authority exercised through the medical staff.

Q And how do you see your role as division director . . . the superintendents?

A They are directly responsible to me for carrying out their responsibilities in terms of the overall institutional management [46] and hospital management. There are—there are requirements for such in the Joint Commission again that the superintendent or chief of the medical staff meet periodically with the governing board, and by their understanding I am the governing board, so we have quarterly meetings in which we discuss issues of concern to the entire state system, particular problems about the medical care, certain policies and regulations that have state-wide impact. For example, issues about convalescent leave which are addressed in the Georgia Code, that would be a topic for this kind of discussion. The question about setting admission policy, again, it has to be understood, that the administrator's responsibility to do with the technical requirements of law, that one has to be careful that the administrator who is also an M.D. is not

constraining the rights that an individual physician has to practice medicine under the Practice Acts of Doctors. To meet that act they are qualified to make certain kinds of decisions, and my judgment won't impinge on that process. We do have continuing education . . . for physicians, for other professionals in terms of keeping their level of expertise where all of us would like for it to be.

Q Are there particular local conditions that might mean different hospitals would have procedures different from other hospitals, for example, that if the two hospitals in Atlanta, because of community resources here might use different admissions process than hospitals in more remote areas?

A Yes. Hospitals in more remote areas, generally the older hospitals, have traditionally had—the state has, for example, [47] provided quarters for housing physicians so there are physicians on the grounds, and available on a twenty-four hour basis, while the other hospitals, the Atlanta Regional Hospital, which is not a residency training program, does not have a residency training program, they use a contract basis with physicians to cover the after-hours, weekend work. The Georgia Mental Health Institute, which has a training relationship with Emory University, uses second and third year residents in psychiatry as part of their admission process, so it varies to some degree depending on the availability of staff, affiliations that the hospital might have.

Q And again, perhaps, in somewhat more detail, what other responsibilities do you have besides overall direction of the seven regional hospitals?

A Well, for all the hospitals, the mental hospitals, the mental retardation hospitals. There are thirty-four or

thirty-five alcohol-drug programs across the state, community mental health centers in which we—the state provides money into these programs. We have foster homes, group homes, so I'm involved in the total system of mental care in the state, setting standards for group homes, for example, standards for family care, standards for community mental health centers.

Q In your first examination, you said that five of the hospitals are not accredited by the J.C.A.—J.C.C.H.?

A J.C.A.H.

Q J.C.A.H. Are they licensed by somebody else?

A They are licensed by the standards and license unit of the division of physical health for the department.

[48]

Q You stated that the act of admission is an act of medical practice?

A Yes.

Q Do you see any distinctions with regard to that statement between voluntary and involuntary admissions?

A Yes, I do. I see a distinction in the sense that the voluntary admission process is based on the evaluation in terms of the individual or client's need for hospital care, illness or disorder and a need for hospital care, where involuntary hospitalization is based on the presence of mental illness plus certain criteria in terms of dangerousness to self or others, for example under the medical commitment law, so that there are more stringent criteria on the physician in terms of involuntary commitment. It still is medical judgment whether to admit or not, but that judgment has to relate to dangerousness issues. The judicial commitment part of the law requires that when a

judicial board finds somebody in need of commitment, that they be admitted. In that sense we admit and evaluate and may discharge immediately if in our judgment they do not require admission because of their medical status, but I think there's a major separation in terms of the physician's responsibility between those two.

Q So are you saying there's a group of people who might benefit from hospitalization in the professional opinion of the medical directors, but would not meet involuntary criteria?

A Oh, yes, there's a group of people. In fact I would think that primarily people who are in need of treatment, hospital treatment, and who are unwilling to receive it, the large majority of those [49] do not meet dangerousness criteria, so we have that struggle with historical traditions of not only the state but throughout the nation, . . . people hospitalized if they should be in a hospital, there's no criteria—no specified criteria about dangerousness. In that regard, we refuse to admit, even though they need that hospital care but do not meet the dangerousness statute. And what we would attempt to do is try to persuade that person to either hospitalize himself voluntarily or to consult a community mental health center, or try to advise the family members of what other alternatives are available in that community should the identified patient change their mind at a later date.

Q Looking just at the group of mentally ill divisions serving, and not the mentally retarded, do you know whether or not as a rough estimate, more than half are being served voluntarily?

A The entire community program and the hospital program?

Q Including the community programs.

A The large majority are being served voluntarily.

Q Would you say seventy-five percent?

A Seventy-five to eighty percent.

Q Okay. You are familiar with the voluntary admission statute which says that a parent may apply for a child to be voluntarily admitted. Does the statute also provide that a ward may be admitted on the application of his guardian?

A Yes, it does.

Q Okay. And that would be an adult ward as well as a minor ward?

A Yes.

Q So might there be instances where a ward would say he did not want to be in the hospital, yet he would be admitted on the [50] application of his guardian?

A That's correct.

Q I think you described regional hospitals as being open hospitals. Would you go into some more detail about what attributes make them open hospitals?

A Well, what comes to mind in response to that question is that—twenty years ago would be a rough estimate of time—the mental health care system in this state and in other states was not well developed, and hospitals were generally isolated from communities. In many cases there were walls around the hospitals, so that they were in a sense what Goffman referred to as closed institutions. They are not that way anymore. They are open. They are open in the sense that visitors are regularly there, people from the community are coming in to participate

in programs, they are open in the sense that hospital staff go into the community, community staff comes into the hospital, and they are open in the sense that there has been increased attention to reversing the trend to lock initially and then release in terms of privileges, but to allow people the maximum freedom that they can handle under the circumstances. That's what's meant generally by an open hospital. It's a recognition that you cannot treat mental and emotional disorders without involvement in the normal everyday community life.

Q Do you know when Goffman did his work on institutions?

A No, I can't give a date on that, but I would like to point out that the title of that book is *Asylums*, and inside the front cover it says, "Essays on mental patients and other inmates." [51] "Essays" is not a scientific term. This was a participant-observer study, since it's his own value judgments about what he saw in the hospital, but it was done during the time when the open hospital concept had not permeated mental health practice in this state or in the country.

Q Have there been any more recent studies on the effects of institutions that are more like Georgia's mental health facilities?

A Well, there have been numerous studies that indicate the great pay-off in terms of improvement of the mentally ill, it has to do with the continuity of care between hospital care and community care for example. They—the kind of closed institution or closed society that Goffman talked about, that kind of thinking is reflected in sociology and stigmatization and labeling theory, the societal reaction theory as it was called at one

time. It's important to realize that that is theory. There is a difference between theory and fact. Chef is the sociologist who is primarily the—the person who feels most strongly that—that labeling or stigmatization are the important things in terms of deviants. For example, it's not individually determined, it's what people say it is and that—that influences that behavior to continue to. . . . Walter Gove of Vanderbilt, the sociologist, who holds contrary positions and has done in-depth research, not as a participant-observer, but asking patients what they think, do they feel stigmatized, and his research would indicate that patients are not homogeneous groups of people who respond like cattle, that there are many of them, over fifty percent in some of his studies [52] who indicate they felt positive about the hospital experience, do not feel stigmatized, that some of them improved their personal satisfaction, their role as provider for the family or as housewives. It is important to differentiate, I think, between theory and data, and there's significant data to question this theory. I think it's also important to note that psychiatrists and other mental health professionals are aware that there is a balance between what is individually determined, what's internal to that organism, physiological, psychological, and the impact of social factors, how other people respond—respond to that person, and you are in a sense evaluating both when you try to make a decision about what's the proper treatment, proper response.

NOTE: #905

Q You were present at Doctor Messenger's (phonetic) testimony?

A That's correct.

Q And Doctor Messenger testified with regard to the unreliability of psychiatric diagnosis. What is your opinion

on your reading and study with regard to the reliability of diagnosis?

A My opinion is it's much more reliable than Doctor Messenger indicated in his testimony. For example, if you take the major categories, phychosis, neurosis, personality character disorders, his studies would indicate anywhere from seventy, eighty-five percent, in those broad categories, maybe even better in some of his studies. If you look in a particular, say the major psychosis, for example, schizophrenia being a major psychosis, a major mental health problem in this country, there are cross national studies involving multiple countries where the data would indicate that there is an incidence rate of somewhere around [53] point three five percent of this disorder. There have been studies over the last ten years that indicate a significant genetic factor in schizophrenia. Now, for example, there would be four times the incidence of schizophrenia in the children of a family where one parent is a schizophrenic—biological parent is a schizophrenic. There are identical twin studies dating back to the late fifties, early sixties by Kollman that indicated that if identical twins are separated at birth, if one of those identical twins develop schizophrenia and the other one is tracked down, that there would be at that time, somewhere around eighty percent of the other twins would have schizophrenia. Those figures are now around forty-five or fifty-five percent, but if it's only stigma that identifies schizophrenia, then it's stigma that follows genetic patterns, that's a very interesting kind of stigma. There have also been studies, some of them cited in the Amicus Brief, studies that indicate difficulty distinguishing schizophrenia, which is a essentially a cognitive disorder from —from an out-patient disorder. The U.S. . . . case studies would indicate that British psychiatrists and American

psychiatrists would do very well in that regard. There are some studies for example, that indicate some difficulty in reliability on certain patterns of the test, but the overall end of that study said that the psychiatrists agreed almost a hundred percent on the diagnosis, so . . . bottom line . . . . There have been major advances in depression in the last few years in terms of distinguishing in a major psychosis or manic-depressive group, which clearly respond to a drug called Lithium. [54] There have—part of the revolution in mental health care has had to do with development of anti-depressants, for example, and there are ways to diagnosis the kind of depression that is more likely to respond to an anti-depressant medication. So obviously something is happening here that differentiates this group A that gets treatment B and improves, from general groups of people. It's like diagnosis in any field of medicine. It's not one hundred percent perfect, but the studies range from—if you're looking at observer agreement, then it would be fifty-five percent, if you look at some of them diagnostic concordance, then you'd see figures as high as eighty-five, ninety-five, ninety-seven percent in some of the studies, so it's not something you can make a global statement about, that all psychiatric diagnoses are unreliable.

Q Has—in general has the research in the last ten or fifteen years shown that diagnosis is more reliable?

A Oh, yes, it's shown that diagnosis is more reliable, and it's getting more specific as you develop more effective treatments. It was only in the mid-fifties that psychopharmacology was able to do anything major in terms of treating the mental illnesses. Medical history is that when you begin to develop from research a specific treatment approach, then diagnosis makes a greater difference.

The difference between British and American psychiatrists at one time in diagnosing schizophrenia and manic-depressive illnesses, it really made little difference because of treatment for the major psychosis, and they're both major psychoses, had to do with using major tranquilizers like Thorazine. When research began to indicate that in view of this [55] specific criteria you could separate off the manic-depressive with a bipolar affective disorder, and treat them with Lithium, then the specificity in terms of that diagnosis began to increase. The same thing has occurred in depression, for example.

Q Would this be true in medicine as well as in psychiatry?

A Oh, it's true across all medicine, psychiatric medicine or physical medicine.

Q You were talking about the adolescent unit at Central State Hospital and you stated that you had plans to merge the adolescent unit with the children's ward . . .

A That's correct.

Q . . . into . . .

A That's correct.

Q . . . the present children's building. Have those plans been made definite yet?

A Well, we're working toward a date in mid-December in terms of the use of the new hospital in Rome, the opening of the children's and adolescent's unit, which would allow us then to move those adolescents at Central State from that northwest Georgia area closer to their home, and would allow us then to combine the units, but it was a step-wise process involving Columbus and involving—and involving a reduction then of admissions of children

as well as adolescents, as children's services developed in the other regions, there were less children in our children's unit and less adolescents on the adolescent's unit, there was the opportunity for combining, and that effort has been on-going for some time as is reflected in the gradual reduction of both of those populations.

[56]

Q Has it been on-going since about the time of that study Mr. Goren referred you to, about the mental health services for children?

A That would date very close to it.

Q And would you expect that the merger would take place sometime in January, '76?

A If things go the way I expect them to go, I hope it'll take place before December ends. I might say that that process was speeded up when I visited the adolescent unit. I made it very clear that while I did not see that as an unacceptable, inhumane, totally destructive place for people to be, I did not feel that it was the most desirable of environments for adolescents, and requested of Doctor Philley and Doctor Zepatera (phonetic) that we begin to move as fast as we could.

Q We referred briefly in the first examination to the provision of legal services to patients. Could you state in more detail what you've done to provide legal services to the patients and what referrals were made?

A Well, I would think the thing that I've done that's been most important is essentially a sensitivity on the part of my office and me to issue the patient's rights. That sensitivity then, influences the whole system. In terms of specific things, the personal advocacy unit which

is a part of this division, was at the time I came aboard, has had my full support. They are essentially a central office staff who act in an . . . type role for patients who feel that they're not being—their rights are not being properly protected. There's a booklet, for example, entitled *Patients' Rights* that is given to all patients on [57] admission that shows in pictorial form and in simple English that should be understandable to all, what their rights are, and gives them the advocacy number so that they may call and indicate if they feel that one of their rights is not being respected. The hospitals also use the legal services offices around the state as a referral source when somebocy wants legal assistance. In the metro area they use things like Atlanta Legal Aid, and are encouraged to do so.

Q And what have you done at Central State Hospital?

A Well, not only the overall sensitization issues but in terms of working with Georgia Legal Services and providing them a place, an accessibility to patients and staff, and I feel that I've been as supportive of that process as it would be possible for a division director to be.

Q And you've provided space at Central State for a lawyer from the Georgia Legal Services, is that right?

A That's right.

Q And do you know how often a lawyer is at Central State from Georgia Legal Services?

A I believe that's twice a week, but I'm sure it's practical.

Q But in addition to the office there on the grounds of Central State, in other parts and in other hospitals, referrals would be made to the local legal aid office, is that correct?

A That's correct, or we would assist a patient in obtaining a private attorney, if that's what they wished.

Q You are also familiar with Doctor Messenger's testimony that judicial proceedings for the admission of children to mental health hospitals would have positive effects on the admission decision and on the child himself. Do you have an opinion in [58] this regard?

A It's my opinion that Doctor Messenger's view is not accurate. I would be personally concerned about the adversarial nature of that process, with the idea that cross examination of parents' right, a child's right, that does not seem to me to square with the parts of Doctor Messenger's statement that I accept, that it's the family system that needs to be looked at as well as the child or adolescent, and if that system is out of balance it may be necessary to hospitalize a member, and sometimes that member is not the child or adolescent. It may be one of the parents. But it seems to me that that kind of fact finding adversary kind of approach is not going to be conducive to proper mental health care.

NOTE: (Brief off the record.)

Q Do you have any special units within the division, Doctor, to handle children and adolescent services?

A It was established some months after I became the director, an Office of Child and Adolescent Services, which I not only established but recruited a child psychiatrist to head, Doctor John Philley, and have given full support to the development of more extensive community services for children and adolescents. That was one of the areas that was increased in our budget during the last year which did not fall during the special session of Congress, so that there's been a major effort on my part to

encourage the growth of alternative services in the community for children.

[59]

NOTE: (Brief colloquy.)

Q Are you familiar, Doctor, with any studies with regard to the effect of institutionalization on children, whether or not they're stigmatized by institutionalization?

A Well, there is a study published by the Vanderbilt University which was commissioned by the—the study was commissioned by the Department of Health, Education and Welfare, under Elliott Richardson, and the—Mr. Richardson's mandate was that they look at the supposed damaging aspects of labeling on delinquents, on mentally ill children, mentally retarded, etcetera. This is a study that involves probably a hundred and fifty people in the field, professional people of all disciplines, and it's entitled *The Futures of Children*, and there is a statement in that document that those people who wish to speak conclusively about the so-called stigmatized and labeling influences on children should speak with extreme caution, because the data do not indicate impacts, upon —significant impacts which can be substantiated on the identity of their sense of self. It should be the major work in the field.

EXAMINATION BY MR. GOREN:

Q Doctor Skelton, you said those facilities which weren't accredited were licensed by the state?

A That's correct.

Q The entire—each regional hospital is licensed by the state?

A It has a hospital license, a state hospital license.

Q Okay. Even for instance, the Walker Building at Central State is licensed as an adequate facility?

A Yes, it's licensed by the state.

[60]

Q Okay. Based on your view and the people that you've cited and the studies of stigma, are there people who in fact disagree with those views, other psychiatrists?

A Oh, yes, there are psychiatrists that hold with the stigmatization and the labeling theory. The distinction I was trying to make was between theory and scientific fact, and it appears to me that the fact does not substantiate the damaging aspects ascribed to stigmatization and labeling.

Q Are you saying that they're not as damaging as generally believed, but they are to some extent damaging?

A No, that wouldn't be an accurate interpretation of the way I put it. What I indicated was that psychiatrists and other mental health—mental health professionals recognize social influences on behavior as well as influences that arise internally, to a person, and how to look at those.

NOTE: (Brief off the record.)

Q Doctor, as far as your discussion about diagnosis, are there people, other psychiatrists that disagree with the—with the people that you cite in your opinion as a reliability on the validity of diagnosis?

NOTE: #1018

A Well, you can't disagree with a scientifically proven study. It's not a matter of opinion, it's a matter of fact in science, indicate—the studies indicate reliability to a certain degree. Now they may vary between—some

studies show very high reliability, some show less high, but an opinion is not really worth anything until it's backed up by some kind of data.

Q But if there was data to show this, then you would say there [61] would be disagreement?

A Well, there could be a disagreement, there could be a—there can be a problem on how certain data is interpreted. For example, as to whether certain other factors are considered in making conclusions about this kind of data.

Q Okay. You also said you were concerned about the adversarial process you thought would occur in a hearing. If a family has a child they want to try to admit to a hospital, isn't there already disruption in that family?

A Oh, yes, there's generally disruption in that family. The studies would indicate that the act of admission to a hospital whether it's an adult or a child, appears to be an act of last resort, that there are attempts to use a variety of social and health service agencies to try to handle the problem before people resort to request a hospital to handle that problem.

Q Are there cases where it's not used as a last resort?

A Oh, I'm sure there are times where people come to the hospital early in the process, but the studies would indicate just the opposite, that the act of hospitalization is an act that is not taken lightly.

Q What studies are you talking about?

A What?

Q What studies are you referring to?

A Oh, I can cite the studies, some of the studies of Gove, for example. There are a number of others I

don't memorize references, but I have them across the hall if you'd like to look at them. They'll be provided in the Amicus—answers to the Amicus Brief.

[62]

NOTE: (Brief off the record.)

Q Doctor, would any delay that might occur in an admission to a hospital due to a hearing prior to commitment in a non-emergency admission of a juvenile to a mental hospital be detrimental?

A Well, I'd be less concerned about a time delay than I would about the process that goes on in an adversary hearing, in a non-emergency circumstance then as long as it didn't sometimes delay the . . . while other alternatives were being explored. I'd be less concerned about the time delay than I would on the impact on that kind of procedure on the child or adolescent in the family.

Q Okay. You also mentioned in regard to services you provide a personal advocacy unit. Don't they also represent the staff in the mental hospital system?

A The—they are members of the staff, of the division. Their mandate from me is to try to act in a neutral objective fashion in terms of any complaints that are . . . to that unit. It is in my view inappropriate for the personal advocate, for example, to take any view initially that either the patient is correct or the staff is correct, and there have been times—there have been circumstances when it appeared to me that the advocate was taking more of the point of view that the staff are wrong. It seems to me that the staff primarily respond in good faith as do patients. What's needed is as objective an evaluation as is possible, in an attempt to be of assistance.

Q So that unit, then, does not solely represent the rights of the patient, am I correct? It's more of a neutral position as [63] opposed to solely representing the patient.

A Represent the rights of the patient as opposed to the rights of the staff?

Q Yes.

A I don't think they look at is as an either-or kind of situation to them. If it's clear to them that the patient's rights are not being respected, then they represent the patient. But usually things are not that clear in the everyday world of trying to take care of the mentally and emotionally ill.

Q You also referred to Atlanta Legal Aid. Haven't they stopped taking referrals from mental hospitals because of their case load problems?

A I think that's true. I don't know that for a fact.

Q Are you familiar with the case load problems of the Georgia Legal Services offices throughout the state?

A I understand from what I'm told by Georgia Legal Services that they're innovative. (Laughter.)

Q Can you just explain to us what the function of the Office of Children and Adolescents is?

A Well, at the time that I became a division director there was one staff member and a district nurse who was the primary central office focus for the development of child and adolescent services. It had only been a year prior to that that the first appropriations specifically for community services for children was in the budget, although there had been services developed out of general adult funds. There was a need for someone that had not

only an awareness of the needs of children—needs for child and adolescent services, but also someone that had a public health [64] commitment of a similar nature to mine to assist in utilizing those new resources that were being made available in the proper way for child and adolescent services, and that's Doctor Philley's role, in terms of assisting local community programs and developing new child and adolescent services and assisting hospital staff and their programs of treatment. He exercises that role through personal contact, through quarterly training sessions with the child and adolescent staff from all over the state, hospital and community staff. So it was a perceived need on my part to recognize, as I do, the specialty area in terms of services for children and adolescents.

Q Okay. And is that office also going to—are you going to establish an advocacy unit for children?

A The present advocacy unit operates across the entire spectrum of disabilities. . . .

Q How many people are in that unit?

A There are three full time staff assigned to that unit.

Q And they serve the entire state?

A They serve the entire state. Certain of the hospitals will have identified staff members who are assistants who will be designated to work with them in terms of those hospital programs.

Q Okay. Finally, are you familiar with Doctor Zepatera?

A Yes, I know Doctor Zepatera.

Q Do you think that there is difficulty in communicating, or there may be difficulties in Doctor Zepatera's communicating with others, in particular her patients?

A I've only had close contact with Doctor Zepatera since this [65] case was filed My own view is that she handles the English language quite well and seems to be a very sensitive psychiatrist.

Q And you don't see any difficulty with understanding her?

A I've had none.

Q And you have not had any experience where she's had any difficulty understanding anybody else?

A She didn't have any difficulty understanding me.

Q Okay. No further questions.

END OF DEPOSITION

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR DONALD G. MILES and DOCTOR WILLIAM WIELAND, taken on the 4th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
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[2]

MR. GOREN: The stipulations and all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The signature of the witness was specifically waived by his attorney of record, DOROTHY Y KIRKLEY, ESQ.)

[3]

DONALD G. MILES, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A Donald G. Miles.

Q And where are you employed?

A Georgia Mental Health Institute.

NOTE: (Defendant's Exhibit Number One was marked for purposes of identification.)

Q Would you identify Exhibit Number One?

A That's my curriculum vitae.

Q Okay. And you have a Doctorate in rehabilitation counseling . . .

A Yes.

Q . . . is that correct? Would you explain what the duties of your position at G.M.H.I. are?

A All right. In a nutshell, they are the general administration of the institute as one of the state's regional hospitals that serves twenty-six northeast Georgia counties, and I also chair the northeast Georgia Mental Health Consortium, which is G.M.H.I. [3] and four community mental health centers that join together in partnership to provide the mental health services to this region.

Q Now, the four community mental health centers, do they serve all counties within that area?

A Yes, we're totally contiguous, the four centers and

G.M.H.I.'s boundaries are the same. The four of them together are the same as the total G.M.H.I.

Q Do the four centers have satelite offices?

A Yes, they do.

Q Is there a satelite office in each county?

A No, not in each. In some of the smaller counties they may share between two or three counties in a centrally located one, but there is some fairly accessible, even in the counties with only three or four thousand population.

Q Does G.M.H.I. and the four community health centers serve children and adolescents?

A Yes, all four centers have children and adolescent service programs, as does G.M.H.I.

Q Okay. We asked you to get together some information on admissions of children to G.M.H.I. since 1969. Have you got that data with you?

A Yes, these are five years of data.

Q Is this the same thing or is this continuous?

MR. WIELAND: One is for children, one is for adolescents.

NOTE: (Defendant's Exhibits Numbers Two and Three were marked for purposes of identification.)

Q Would you identify Exhibits Two and Three, please?

[4]

A All right, Exhibit Two is the printout of the last five years of patients discharged from the adolescent unit, and Exhibit Three is the printout of the last five years of

patients discharged from the children's unit, including admission date and discharge date, diagnosis, type of admission, who admitted them and who they were released to.

Q And who prepared these, Doctor?

A Our patient information office, medical records office.

Q And do you have information on your current patients?

A Yes, we have social histories and some intake information on each of the current residents of those two units.

NOTE: (Defendant's Exhibits Numbers Four and Five were marked for purposes of identification.)

Q Would you identify Exhibit Five—Four?

A Exhibit Four is the mental history, including some social history on the patients currently resident in the adolescent unit.

Q That's for each patient individually, is that correct?

A Yes, each patient individually. And Exhibit Five, is the same information for all of the resident patients on the children's unit. The dividing age between those two units is approximately age thirteen.

Q Now would you describe, please, the admission process for children to both the children and adolescent units?

A All right. And I do have a written policy statement on that, but I'll summarize briefly what that is. We have so organized our regional mental health services that the ordinary and usual method of admission is to apply to the

community children and youth service program in each of the four community programs. The staff there then do a preliminary evaluation and develop a [5] plan of action. This will include contacts with the teachers, the parent, if there is a court involved, with the judge, and any pertinent parties involved in making the decision. Probably only one in a hundred children referred is referred on to G.M.H.I. for hospitalization. The intent is to provide community services wherever feasible, and only where either a complex diagnostic situation exists, or where there is no possibility of providing the needed treatment while the child is living at home would the referral be made to G.M.H.I. But when they—the child actually arrives at G.M.H.I. there has, in most cases—I'll tell you about the exceptions in a moment—but in most cases, been this advance evaluation and planning and either telephone or in-person contact between the community child and adolescent staff and the hospital child and adolescent staff, so we're fully informed, I'm sure. But with the children's unit, I asked the unit director recently about that, she could think of no child in the last year that had not been previously evaluated in the community. The adolescent staff has about one every month that was not evaluated in the community. The ones who are not, and essentially are, therefore, by-passes of our system, come in and are seen by the—in this case it would be the adolescent staff since this doesn't happen in the children's program—are seen by a staff member, including the child psychiatrist if it's daytime hours, or the psychiatric resident if it's nights or weekends for an evaluation. Also by telephone the on-call person in the community program is contacted, and any information they have or can obtain withan an hour or so while the proposed patient is waiting is pulled together, and then a [6] decision is made

whether or not to admit based on both the interviews made and the information that can be obtained from the community.

Q These adolescents that are admitted without going through a community program, are they voluntary admissions or court ordered?

A They are usually voluntary. The court ordered ones we usually have advance notice from the judge. We've been working with the judges sufficiently that in most of those cases the judge has made advanced contact with us and we have had a community staff member consult with the judge.

Q In cases of direct admission, what sources of information would the hospital staff go to to find out about the history of this child?

A There are—now this is the case of the non-community transfer case . . .

Q Right.

A . . . the one who walks in—however he gets there.

Q Right.

A Okay, well, in addition to the interview with the adolescent, himself or herself, there's usually somebody that's brought them, a parent or a relative or a friend is usually involved, so there's an interview with whoever brought them. Then the telephone contacts to the community program asking them to investigate. About half the time the community program know the child and can immediately say, "Oh, yes, we've been working with them and here's what the plan is," and, "Yes, we do think it's all right for you to admit," or "No, we don't," and, "He's just running away from our treatment pro-

gram, send him back." Sometimes we're [7] not able to find out any information from the community people. There will be a phone call made to the family physician, to the parents if they aren't with the child, any logical source to try to understand what is bringing this child to the hospital.

Q Do you have written policies on admissions?

A Yes.

NOTE: (Defendant's Exhibits Numbers Six and Seven were marked for purposes of identification.)

Q Now if you would identify those next two exhibits.

A Exhibits Six and Seven are the Georgia Mental Health Institute's admission policy, which is the formal statement of that general summary that I gave about how patients of all ages would be received at the institute. It doesn't specify children, but the policy is the same for all age groups.

Q Who issued this policy?

A I did.

Q How long have you been superintendent?

A Three years in March.

Q And do you have any special policies relating to the admission of children?

A Yes, we have a general statement. We had a committee getting together to plan all of the details of this general policy, how will that work specifically for children, and that was set forth and all of its sub-objectives and responsibilities assigned for people who would see that what I have said really happens, and this, which I suppose you'll want to admit, is the statement of those policies and objectives for children specifically.

Q And did you issue that policy statement as well?

[8]

A Yes. Yes.

NOTE: (Defendant's Exhibit Number Eight was marked for purposes of identification.)

Q And Exhibit Eight is the memorandum we've been discussing about the application of these policies to children and adolescents . . .

A Yes, it is.

Q . . . is that correct? In your community programs and also when a child is admitted to the hospital, is any provision made for the joint treatment of the parents or other members of the family?

A Yes, it is, and one of the policy statements in there is the—is that that will be done and it outlines the method whereby the decision will be made as to who will be working with the parents, so that in every case someone will be working with the parents, and there's a mechanism for deciding whether it's the community program or the hospital staff or both who will do that.

Q Can you summarize that?

A All right. Well, that is part of the negotiation at the time of admission, and that—the decision is based generally on what looks like the discharge plans for the child, so that if it looks like we have an intact home and the child will be returning home and there will be a continued treatment plan, then it's likely that the community staff will do the work with the family if we're to keep that

continuity going. They may come to the hospital to do this, and the hospital staff may join with them in doing that, but on the other hand if the family is not intact and this is a D.F.C.S. custody case, then it may be that whatever contacts can be made with community people will be done by the [9] hospital staff, but in every case it's negotiated at the time of admission and written in the treatment plans as to who is going to be doing what.

Q What about in community treatment before a child gets to the hospitals, would the parents also be involved on that level?

A Yes. Yes, all of our community programs are very much family oriented. Whenever there is a family included in treatment, the method is family therapy.

Q Is there any way that you require parents to have therapy?

A Yes. Sometimes they won't agree, but we try to contract, literally, with parents to participate in the treatment of their child. Many parents like to do this because we have methods of training parents in how to better deal with their children, and most of them are eager to learn how to be better parents, so that is not a frequent problem in getting them to participate in these programs.

NOTE: (Brief off the record.)

NOTE: (Defendant's Exhibit Number Nine was marked for purposes of identification.)

Q Okay, Doctor, would you describe Exhibit Nine, Please?

A All right. Exhibit Nine is a count of the number of children and adolexcents since July 1 of 1967 who have

been seen at the institute and evaluated and indicating then, which ones were rejected for admission, or how many of that total were rejected for admission. Since we reorganized and shifted the responsibility for making those decisions to the community program in '73 and '74 and '75, we have stopped keeping the information, although [10] as I mentioned earlier there have been a handful, but we didn't have the record system to indicate how many there were.

Q Prior to '73 you were evaluating children and adolescents first? They had not been through a community program?

A There were all evaluated at the institute up until '73.

Q Now this list for '71 through '72, it just shows the number evaluated?

A Again, the records—we didn't keep the records of that, although that did precede the reorganization. The pattern in '70 and '71 and those prior years would be predictive of '71 and '72 also.

Q You were using the same system . . .

A Yes.

Q . . . in '72 and '73?

A Yes. It wasn't until '73—mid-'73 that the system changed.

MR. GOREN: When you refer to the system, is that the community based . . .

A Community based evaluation.

MR. GOREN: . . . the idea that those people would be admitted—adolescents to the community first, is that what you're talking about—that change?

A Yes, that change took place in mid-'73. Prior to that time they were all evaluated at the institute.

NOTE: (Brief off the record.)

NOTE: (Defendant's Exhibit Number Ten was marked for purposes of identification.)

MR. WIELAND: See, the institute didn't become our regional hospital until 1973 . . .

[11]

Q Would you identify Exhibit Ten, please?

A Exhibit Ten is a proposal which was endorsed just yesterday by our Regional Management Consortium Committee, which takes one of the objectives from a previous exhibit, Exhibit Eight, having to do with the responsibilities for longer stay children and the placement problems of longer stay children, when it's time for them to return to the community. That gets very specific on how that will be done and establishes a review mechanism so that cases that stay beyond three months will be regularly reviewed to determine what work is being done by whom and what the progress is toward making a placement.

Q This is with specific reference to placement back in the community?

A Yes.

Q Who would be involved in that planning and review?

A The committee that does that is a combination of staff from the four community programs and from the children and adolescent units. They get together and jointly do these reviews and make the decisions.

Q How often are reviews made past the three months?

A Well, periodically. Every three months on these long stay cases, they will do a review,

Q Do you have a general policy in the hospital for the review of all patients?

A Yes. That would apply also to these long stay and also to the shorter stay patients, but there is regular peer review mechanism and then a hospital-wide review, services review committee that reviews these cases regularly.

Q Do you have a written policy on periodic review for the whole [12] hospital?

A Yes, we do. This is our written and approved utilization review plan, which again is for all age groups but does apply to the children and youth.

NOTE: (Defendant's Exhibit Number Eleven was marked for purposes of identification.)

Q And Exhibit Eleven, Doctor, is the utilization review plan for the whole hospital, is that correct?

A Yes, it is.

Q Did you issue this plan?

A Yes.

Q And it's dated November 7th, 1975?

A Yes.

Q Was there a plan in effect prior to this one?

A Yes. Yes, this meets some new Federal requirements, so it's really a revision of the previous plan.

Q Does it have any specific time deadlines in which cases have to be reviewed?

A Yes, it does. If we could turn to Doctor Wieland,

who chairs this committee, I think he can give you more accurate information.

DOCTOR WILLIAM WIELAND, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

A We put in the general policy that our cases have to be reviewed at least within the first thirty days—they are reviewed right after admission and then within thirty days. The first review is to look at the appropriateness of the admission in the first place, and the second review is to look at the length of [13] time and whether that's appropriate. In practice, we're actually reviewing cases after twenty-one days.

Q Who would make this review, Doctor?

A The service review committee meets once a month, and the medical records reflect cases who've been in the hospital for more than twenty-one days.

Q Who is on the committee?

A It's—involves all disciplines, a representative from each adult, alcohol and drug, and children and adolescent unit, these people may be social workers, nurses, or mental health workers. It also includes two physicians, and the Director of the medical records.

Q And that committee meets once a month to review all patients?

A Yes, and then all the longer stay patients are also reviewed by another physician from another unit who then further makes a determination whether longer stay is appropriate.

Q Are there any particular additions to that with regard to children, or is the policy pretty much the same?

A No, this particular policy is the same for both children and adults.

NOTE: (Defendant's Exhibit Number Twelve was marked for purposes of examination.)

Q Doctor Wieland, is Exhibit Number Twelve your curriculum vitae?

A Yes, it is.

Q Is there anything you want to add to that, or is that up to date?

A No, it's a recent one.

NOTE: (Brief off the record.)

[14]

EXAMINATION OF DOCTOR DONALD G. MILES, CONTINUED:

EXAMINATION BY MS. KIRKLEY:

Q Now, Doctor Miles, after you've reviewed a case, and it appears that it's time for a child to try to be placed back in the community, do you find that you have substantial problems with natural parents who refuse to take their children back?

A That is a problem area. It doesn't happen in the majority of instances, but it only takes say one out of every twenty, to, over a year or two accumulate a group where we do have troubles, and that is a—therefore a significant problem, where we have families who have lost interest or willingness to work with us and with their children. We have even had a couple of occasions where they moved out of state to avoid responsibility for taking their children back again.

Q What steps do you take when you see this happen?

A We've done some detective work to find out where they went and get in touch with them and try to determine whether or not there is any prospect for there taking their child back. Now, when they have gone to those lengths, it's usually a good indicator that we shouldn't be placing the child back with them anyway, in which case we work with D.F.C.S. to transfer custody, and worked out a foster placement for these types of children.

Q D.F.C.S. is the Department of Family and Children's Services . . .

A Yes.

Q . . . in the county of residence, is that correct?

A Yes.

Q So you have a relationship with D.F.C.S.?

[15]

A Yes.

Q A continuing relationship to refer cases to them as necessary?

A Yes, we do. Again, this is jointly the community program and the hospital staff who make these arrangements. The community staff keeps that liaison with the D.F.C.S. office wide open.

Q You are familiar, Doctor, with one of the claims in this case, that judicial proceedings should be used prior to the admission of children to a hospital on the application of their parents?

A Yes.

Q In your opinion as superintendent of G.M.H.I., would judicial proceedings in all voluntary cases improve the admission process?

A I don't see how they would. We have tried to be as thorough as possible. We've philosophically felt that we needed as many people involved as possible and as thorough a community evaluation as possible, and I think we've done it, and I don't believe that that would add anything to the decision making. I think it might, in fact, prevent some children from getting into treatment as early as they should in some crisis situations.

Q That's all the questions I have.

EXAMINATION BY MR. GRANBERG:

[17]

* * * * *

Q And are there any rules, policies, etcetera, in regard to the items or the subjects to be covered in the interview other than the basic information which is mentioned on page three of this policy?

A There are no formal policies on that. There is a fairly standard kind of approach that any clinician trained to work with children would use and is trained to use, but that is not a matter of policy.

Q Okay. Who actually does the admitting? Who is qualified, all physicians?

A Yes—well, yes. Although we have a child phychiatrist who has had training beyond the general psychiatric residency in child psychiatry, who is assigned to these two units, and will be providing that. By law any physician can do it. In our case it is a physician who happens to be a child psychiatrist.

Q So the child psychiatrist is the one who makes the ultimate decision for admission?

A Yes, unless it's night or weekend admission, and since most of our admissions are planned for this age group, that is rare, but it's possible that it would be one

of the psychiatric residents in the Emory training program who will do that. [18] They are fully licensed physicians, but occasionally it's not . . .

Q Sure. I should also say that when I'm talking about admissions, I'm only—unless I say so, it would be non-emergency admissions, okay?

A All right.

Q I'm sorry I didn't clarify that. Are there any policies in regards to location of the psychiatric interview?

A No. The location, if it arises at G.M.H.I., the situation is one that's presenting there, and has not been screened in the community—or has been screened in the community, in either event, the next step is on the unit, in the office.

Q It's always in the child psychiatrist's office?

A Or it may be in the social worker's office, the chaplain's office, there is an inter-disciplinary decision that's made.

Q There—you mentioned the use, when it's referred from the community, of secondary resources, namely schools, I think you mentioned specifically . . .

A Yes.

Q . . . and interviews with other people in the community. In regards to the community and the use of those secondary sources . . .

A Yes.

Q . . . are there any types of methods or policies utilized in existence in the—through your office which provide for verification of those secondary sources, . . . information from those secondary sources?

A No, if they are reported on the transfer sheet from a community program, we accept their word for it that they have made the [19] contacts that they say they have.

Q And if it's not referred from a community mental health center, then is there any way—any policies as to—psychiatrists or the admitting physicians, obtaining information by secondary sources?

A Yes.

Q And . . .

A As I mentioned there will be—if it's not a referred case by the community program, there will be a telephone check while the child is waiting, to find out as much information as possible, but sometimes it takes a day or two to obtain a full report, so they get enough to try to make a proper decision, but then it's another day or two before they can verify it, which is sometimes directly themselves, and sometimes by the next day having the community staff make a visit to whoever is involved and report back to them.

Q In that period—in that interim, where is that child who is sought to be admitted?

A All right. If the initial evaluation indicated that there was a reason to be admitted, he would be admitted while this was taking place. If they could find no reason to admit or no reason not to treat in the community, then they would send him home.

* * * * *

[21]

* * * * *

Q But again—okay, maybe we should define an emergency situation, because I'm talking—I realize your concerns with crisis situations. It's also very important,

and we share that, but we are talking about—all of the questions I'm referring to, we're talking about non-crisis and non-emergency situations. Maybe, if you would, just define what you consider to be an emergency or crisis situation?

A All right. It may be a crisis because of the child's illness or it may be a crisis because of the family's circumstances. The latter occurs probably more frequently than the former. If it's the child that's having a crisis, in fact we can often treat them at home, because the home is more likely to be stable, but if it's the home, you know the father is in an alcoholic rage and beating the mother and the kids, which is a fairly typical circumstance, the urgency of removing the child—well, some intervention is done with that family.

Q So it's basically a situation involving—please, I don't want to overstate it, it's basically a situation involving danger to the child, a crisis situation?

A Yes, very often, uh-huh.

Q I'm also—I realize sometimes when lawyers and psychiatrists talk, there's certain terms that engender bad responses like medical determinations, professionals, and when we say things like liberty and—sometimes there's feelings of conflict between those. I—just listening to you talk, though, I'm sure that your concern for liberty, the rights of liberty of a child are [22] evident, and it seems to me your institution has made that especially clear in its desire to implement policies, making sure that no child is institutionalized incorrectly or unnecessarily.

A Yes.

Q Okay. Considering that and the other things that we were just talking about, if—would you find it unduly burdensome if all this information that's available, could be gathered, and representatives from different groups, namely psychiatrists, social workers, child care workers, D.F.C.S. workers, your community mental health people, could present all this information together to an independent arbiter, even perhaps a judge, a Probate Court Judge, a Juvenile Court Judge, or some other person, would that unduly burden the functioning of the hospital?

A I don't—I don't know. It would probably depend on how that was done since we—we attempt to gather that kind of information anyway and feel that it's proper to be that thorough in making these kinds of decisions, so if that could be done without staff having to leave their jobs to go do this, and if the material could be transmitted as readily as we're transmitting it now, then that should not be too burdensome. I guess I would be concerned that it might turn into a big paper procedure.

Q Surely. But if all the people got together who had some information on the child, wouldn't that enhance the likelihood of a valid diagnosis, if all this information was exchanged, and also not only increase the validity of a correct diagnosis and treatment plan, but also the information as to possible existing alternatives that perhaps, individually or even in groups of [23] one—one on one conversations hadn't been thought about?

NOTE: #550

A I suppose as a general rule of human affairs that more heads are better than a few heads, and that's true. I do feel that we have recognized that, and I would be surprised if we very frequently found anything that we were not already on top of, because—obviously we're

sharing similar philosophies, that we need to be very careful to protect these children and to plan carefully so that their futures are not marred by unnecessary hospitalization.

Q Your testimony on direct examination and now just what you're saying again here, seems to indicate that—that you are cognizant of what—the potential conflict of interest between children and parents, is that correct?

A Yes, there is a potential that will occur in a certain number of cases.

* * * * *

[25]

* * * * *

Q Do you have any written policies, procedures, guidelines, [26] written or non-written, that deal with any notice of legal rights to the child that is admitted under the statute?

A I don't know. I don't believe there is anything written, and the—we do have a written procedure for notification of rights to all patients of all ages, but the reason I would answer "I don't know" is that for a four-year-old, I'm not sure how that's handled.

Q So you're not sure whether the child is either informed orally or in writing?

A That's right. They may tend to be done more with the parent or guardian than the child, which would be my hunch as to the way that policy is being applied.

Q And the parent or guardian who receives that information, may, as we previously talked about, have a potential conflict of interest with the child?

A Yes.

* * * * *

[33]

* * * * *

Q What is the name of that committee?

A The Youth Services Review Committee. So we have felt if they're there three months, it's time to get alarmed, and do a formal review including community staff to be sure that hospitalization is proper, and that if it's not and they're there simply because they need a place to live, that somebody is working on it.

Q And then those reviews continue . . .

A Every three months.

Q . . . every three months after that. Okay, the immediate review that's done after admission is done by someone not involved with the admission process?

A Yes.

Q Someone different? Who would that be, a physician?

A Well, there's an admission review officer who is not a physician. Those—this is done in accordance with H.E.W. guidelines on review and there's a set of criteria indicators for admission and the review officer just looks at the record and determines whether or not the criteria were met, did the staff apply the criteria in making their decision, and if not, then Doctor Wieland is notified and he gets involved as a physician in determining why the admission was made.

Q And the second one is done within twenty-one to thirty days, who is that conducted by?

[34]

A All right, that is a peer review—interdisciplinary peer review. A physician other than the physician who admitted makes the recommendation as to the necessity for continued hospitalization.

Q Okay. And then after three months there is a Youth Services Review Committee.

A Yes.

Q And that's composed of the—the child phychiatrist committee?

A Well, it's staff from both of those two in-patient units and the four community programs, but does not include the child psychiatrist. The child psychiatrist makes recommendations to them, but . . .

Q The child psychiatrist is the one who is responsible for that child . . .

A Yes, he is in charge of the case, but by that time there is often a placement problem involved, and that's not really a psychiatrist's job. So her recommendations go to that group. The group itself is more likely to be the people who can move the case.

NOTE: (Brief off the record.)

Q Does H.E.W. guidelines apply to all regional hospitals?

A Yes, they do.

Q Okay. I'm just a little bit curious about this Youth Services Review Committee. Are you saying that after the three months—the child psychaitrist is not even at the first meeting after the first three months?

A Not at the meeting.

[37]

* * * * *

Q Now, again, considering your obvious concern with the children, treatment, not being hospitalized where they don't need to me, and also your concern with just—

it seems to me your—a basic civil liberties approach, that a child shouldn't be confined as a matter of law if he didn't need to be, would it be unduly burdensome to have someone independently appointed as an advocate for the child, not so much to fight everything that's being done, but to serve as a representative for the child, trying to represent his best interest—what he considers to be the child's best interest?

[38]

A Obviously I'm pausing because I—kids do get caught in the awful complex webs of situations, and the more that there can be advocacy and thought on their behalf, the better, and I wouldn't argue with that principle at all, it's that I suppose every administrator gets caught in—also bureaucratic procedures that sometimes stifle the very thing they're created to correct, and whether that would do that or not I don't know. I'm in favor of it in principle, though I would need to know what the mechanisms are.

Q Sure. I have no further questions.

EXAMINATION BY MS. KIRKLEY:

Q I just have one question. You talked about parents contracting with the community mental health centers to have family therapy.

A Yes.

Q Do you have any idea of what percentage of parents do contract?

A The majority. Almost all. It must be at least ninety-five percent.

Q That's all the questions I have.

END OF DEPOSITION

* * * * *

EXHIBIT 6

GEORGIA MENTAL HEALTH INSTITUTE HOSPITAL SERVICES

Patient Admission and Evaluation
from the Geographic Service Areas

POLICY 430-2 July 2, 1975

1. **PURPOSE:** To establish criteria and general procedures for the appropriate movement of clients from designated geographic service areas to the specialty services of the Institute.

2. **POLICY:** The Institute and the Geographic Service programs of the Northeast Georgia Mental Health Consortium will operate 24 hours a day, seven days a week as a unified mental health service system to provide appropriate, balanced mental health services to all persons living within the areas served by the Consortium. In particular, all criteria and general procedures stated in this policy are regarded as mutually binding upon all parties served by the system. As a unified service system, the Consortium regards explicit referrals from Geographic Area personnel to the Institute as legitimate transfers between programs within the balanced service system. An "explicit referral" is made by an area staff member who has personally conducted an intervention with and assessment of the client, resulting in a certification by the Area's mental health staff that all levels of care criteria, as well as legal requirements for admissions have been met and that no appropriate alternative resources are available within the client's geographic area.

3. **PROCEDURE:** The following general procedures regarding admission to the Institute are broadly appli-

cable throughout the Consortium. Specific variations must be in writing and jointly approved by the Superintendent, the Deputy Superintendent (Medical), and the appropriate Area Mental Health Director(s). Such variations, and other amendments approved in the same manner, must be reviewed by the same persons quarterly (on the 10th day of July, September, January and April) and rescinded when no longer applicable.

a. Persons **explicitly referred** by staff of an Area Mental Health Service **shall** be admitted to the Institute under circumstances (1) and (3) **or** (2) and (3) below:

INTRA-OFFICE COORDINATION		
TITLE	INITIALS	DATE

(1) Person has been seen and evaluated by Area staff; and if a voluntary applicant, he/she arrives with service objectives agreed to by the Area and Institute staffs. The person must be willing and capable of signing a voluntary admissions form.

(2) Person arrives from a judicial county with appropriate legal authorization for non-voluntary admission and, when possible, prior notification by the area staff with service objectives agreed to by the two staffs.

(3) Person arrives during "normal working hours" (8:00 AM-4:30 PM, Monday-Friday, except holidays) unless another arrival time and date has been arranged **or** person arrives as an emergency admission authorized by a physician.

b. Other persons arriving from medical counties with legal orders for evaluation or recommended admission must be evaluated by the Institute staff who are under the supervision of the Deputy Superintendent (Medical), with a disposition arrived at in accordance with all applicable laws, facility policies and criteria.

c. Other persons (walk-ins, bypasses) not explicitly referred to the Institute by geographic personnel must be screened by the Institute Admission and Evaluation Unit to determine appropriateneness of hospital admission. Persons residing within the service areas of the Consortium will, on arrival, be brought to the attention of geographic personnel (through agreed upon on-call procedures) and shall be directed to appropriate alternative services within the geographic area at the earliest available opportunity.

d. When the area mental health staff determines that a client requires hospitalization, the Admissions and Evaluation Unit will be called and given the following information:

(1) Personal identifying data (name, age, sex, address, phone number, county of residence and mental health catchment area).

(2) Current situation, reason for hospitalization, and commitment status.

(3) Objectives to be reached during hospitalization or evaluation.

(4) Date for which admission is recommended.

e. Admissions and Evaluation will determine whether the patient needs physician's screening and unit of assignment.

f. Voluntary Admission. The Admissions and Evaluation Unit will interview the client and its clerical staff will record on single sheet of Admission Summary (MR 100) with three carbon copies (for Medical Records, ComCenter and Patient Accounts) information as follows:

Name, present address, telephone number, age, nearest relative, person to notify in emergency, patient's representatives, marital status, employer, income, hospital insurance information, and referral source. Plus:

(1) Obtain signed Consent on the reverse side of the Admission Summary sheet.

(2) The Clinical staff will serve the individual notice of Voluntary Rights as a patient and give or send copies to the patient's representatives.

(3) Make or correct addressograph plate. (Include current date and unit).

(4) Stamp 3 x 5 Notification cards and Dictation card.

(5) Stamp routine Lab and X-Ray requests.

(6) Notify unit that the patient is on the way.

(7) Complete MSIS Computer Admission Summary sheet.

(8) Complete insurance papers.

(9) Take picture of the patient.

g. Involuntary Admission. The procedure is the same as above with the following exceptions:

(1) If a person is requested to sign a Consent for Treatment form and does not or cannot because of his/her condition, and meets voluntary criteria, a physician must involuntarily hospitalize the person by signing forms MH 1013 and MH 1014 or MH 2013 and MH 2014. The person must be given an explanation of rights as an involuntary patient.

(2) If a person is accompanied by judicial papers, he/she does not have to be evaluated for admission by a physician, but is admitted. These forms are MH 1026 and MH 1027 or MH 2026 and MH 2027.

h. In the event of disagreement between the Institute and other Consortium personnel regarding a particular admission to the Institute, normal supervisory channels should be utilized to resolve the disagreement. Whenever possible, the patient will remain at the Institute until the disagreement is resolved. Ultimate authority to refuse admission rests with the Deputy Superintendent (Medical) or designee whose explicit intervention is required if other agreement is not reached within 24 hours of the prospective patient's arrival at the Institute.

i. All admission procedures applied to 1) mentally ill persons and 2) alcoholics and drug dependent individuals must be in compliance with Georgia Health Code 88-5 and 88-4 respectively, as currently amended. Supervisory personnel having responsibility for the admission and evaluation of clients are expected to be familiar with these and other codes or legal requirements related to admission procedures, and to adequately familiarize those working under their supervision with the procedural implications of such codes and requirements.

5. **RECISSIONS:** POLICY 430-2, subject: "Inpatient

Admissions," dated September 11, 1974, as amended and POLICY 430-3, subject: "Status Changes to Inpatients," dated May 7, 1974, are hereby rescinded. All copies of the rescinded policies will be removed from Policy and Procedure manuals and destroyed.

OFFICIAL:	APPROVED:
/s/ MELL S. PELOT Mell S. Pelot Deputy Superintendent (Admin.)	/s/ DONALD G. MILES Donald G. Miles, Ed.D. Superintendent

DISTRIBUTION:

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D; E; F; G-2/4/5; H-2/6

Prepared by:

Task Force on System Coordination

Coordinated with:

Policy and Planning Council;
Northeast Georgia Mental Health Consortium;
Coordinator, Admissions and Evaluation

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR JOHN J. GATES and DOCTOR W. T. SMITH, taken on the 4th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs:
GERALD R. TARUTIS, ESQ.
DAVID GOREN, ESQ.
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For the Defendants:
DOROTHY Y. KIRKLEY, ESQ.
Assistant Attorney General
Department of Law
132 Judicial Building
Atlanta, Georgia 30334

[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The signatures of the witnesses were specifically waived by their attorney of record, Dorothy Y. Kirkley, Esq.)

JOHN J. GATES AND W. T. SMITH, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

NOTE: (Defendant's Exhibits Numbers One and Two were marked for purposes of identification.)

Q Would you state your full name for the record, please?

A John J. Gates.

Q And where are you employed?

A Central State Hospital.

Q Do you have a Ph.D,?

A Right.

Q In psychology?

A Correct.

Q Would you identify Exhibit One please?

A This is my curriculum vitae.

Q (To DOCTOR W. T. SMITH) Now would you state your name for the record, please?

A W. T. Smith, and I am the Chief Medical Officer at Central State Hospital.

Q And are you a medical doctor?

[3]

A Medical doctor.

Q Would you identify Exhibit Two? Is that your curriculum vitae?

A Yes, ma'am.

Q Now, Doctor Gates, would you state, please, what your job is and what your duties and responsibilities are at the hospital?

A My title is Director of the Regional Mental Health Center at Central State Hospital, which involves a responsibility for coordinating all . . . administrative, personnel resources to effect patient treatment for a roughly two thousand bed psychiatric facility. That includes adult psychiatric patients, alcohol and drug patients, and children and adolescents.

Q All right. Are there components of Central State Hospital for which you do not have administrative responsibility?

A Yes, the components known as a Forensic Services Center, Medical and Surgical Center, Regional Developmental Center, and the . . . . . Rehabilitation Center.

Q But you have a responsibility for . . .

A And the administrative support of it.

Q Do you have responsibility for the treatment services to mentally ill children and adolescents . . .

A I do.

Q . . . is that correct? And what region does Central State Hospital Serve?

A The portion of the hospital that I am in charge of has three divisions. One of these divisions is known as the regional division, which has responsibilities for—services for a twenty-three county area in middle Georgia. A second division, a state-wide division, which is—deals with adult psychiatric [4] patients, continues to have some responsibility for patients all over the State of Georgia.

Q With regard to children and adolescents, particularly, does the Regional Hospital have responsibility just for those twenty-three counties?

A No, the children and adolescents unit has a major mission of providing services for those twenty-three counties, but because of the fact that the Regional Hospital at Rome is not yet—does not have a functioning children and adolescents unit, we continue to receive youngsters from that area.

Q Do you have within your twenty-three county region, now, excluding Rome, community mental health centers?

A We have one comprehensive community health center located in Macon, a mental health clinic located in Dublin, a mental health clinic located in Warner Robins, and out-patient services provided in conjunction with the Baldwin County Health Department in Milledgeville.

Q And would these facilities serve all of the counties within the twenty-three county area?

A Well, each would be responsible for a designated catchment area surrounding those major cities.

Q Which would include more than just the county in which the facility was located?

A Yes.

Q What is the relationship between the hospital and the community mental health program?

A We have—some of our staff, in fact, assigned to various programs in the community. In other cases we have staff who spend part of their time providing services in one or more of [5] the communities, and generally we

work cooperatively with mental health people in all of those communities.

Q Doctor, what is the admission process for people to the Regional Hospital, with particular emphasis on children and adolescents?

A As much as possible we try to have the community people deal with youngsters on the outside. If a child gets to the hospital, then we have an evaluation team during regular working hours who will screen the individual in terms of suitability for admission. In the case of under-aged individuals, frequently there is a question about the possibility of mental retardation, in which case we also try to involve the staff of the mental retardation unit in the determination. If it's determined that a child requires hospitalization, in most cases he's sent directly to the children and adolescent unit, where the staff there then begin a systematic process of evaluation and treatment as prescribed in one of those documents.

Q Let's back up for just a minute. Do the community mental health programs play a role in the admission process?

A To some degree. The Milledgeville area has a child and adolescent coordinator with a small staff, and we're trying to develop more services. She does relate on a rather routine basis to staff and the in-patient unit. The same is true actually, also, for child and adolescent coordinators in the other three major areas. In addition to the identified community mental health people, we have case workers for D.F.C.S., . . . services workers, and a variety of other people who contact staff of the children and adolescent units who come to—help get them involved in the determination of whether [6] hospitalization is indicated.

Q Do you have any idea what percentage of children would have been seen first at the community mental health program and evaluated there before they come to the hospital?

A I really don't. I can say they have something here which indicates that since 1972—we don't have any records on this prior to that time because we were ordered to destroy some of our files, records management people at the state level—this document indicates that during this three year period we've had—we have a record of fifty-two of the youngsters who were screened by staff of the child and adolescent unit. This was done by following direct contact between a variety of people out in the community and the staff—with the staff of the C&A unit.

NOTE: (Defendant's Exhibit Number Three was marked for purposes of identification.)

A I think that particular document addresses itself specifically to the question of whether or not the staff in the unit, the in-patient unit, have any opportunity to participate in out-patient evaluation or pre-admission screening.

Q This that you are referring to is Exhibit Number Three?

A Yes. In addition to that, I might say, that there is undocumented frequent contacts by phone and personal contact between various staff of the C&A unit, and the same multiplicity of people involved in youth services in the community. We now have identified staff in the C&A unit who team travel to Macon, Rome, Warner Robins or Dublin, for example, on a regular basis to work with the staff out there.

[7]

Q Now when a child comes to the Regional Hospital, is he first evaluated at the children and adolescent building?

A No, generally he's not. The child appears in the admissions office. He is usually seen by what we refer to as an admissions evaluator who may be a doctorate level psychologist, social worker or nurse, in conjunction with the admitting office physician. Hopefully, there are relatives, parents who accompany the child. Their effort is to determine whether or not hospitalization is the more appropriate treatment modalum for the kid. After regular working hours, the children are seen by the officer of the day, physician who is on call, and a determining decision of whether to admit or not is made by that person.

Q During the regular working hours when you have the admitting physician on duty, is the C&A unit involved at all in the evaluation conference?

A No.

Q So the decision is first made by the admitting physician, and then the child is admitted to either the child or adolescent unit, is that correct?

A Right.

Q Does an evaluation take place upon admission by either the children or adolescent unit?

A Yes, as you can see in that document I was referring to here is what we refer to as a responsibility action format, on the top here which generally describes what the procedures are that are gone through.

NOTE: (Defendant's Exhibit Number Four was marked for purposes of [8] identification.)

NOTE: (Defendant's Exhibit Number Five was marked for purposes of identification.)

Q Would you identify, please, Exhibits Four and Five?

A By name?

Q Yes.

A Exhibit Four is an example of an admission program, and Exhibit Five is a memorandum from Doctor W. T. Smith to all physicians regarding required examinations on re-admissions of psychiatric patients.

Q Okay. Now that you've identified both, would you just describe the documents?

A Very briefly, when the child gets down to the C&A unit, there is a physical examination and a mental status examination done generally in accordance with the requirements outlined by Doctor Smith in here. In addition, one of the team members, who may be any one of a variety of kinds of personnel, is designated as a big brother or a big sister. Their task is to get to know the child, to spend a certain amount of time with the child every day during the evaluation period, to make entries in the chart as to how the child is doing. In the meantime if a psychological evaluation has been ordered, a social history has been ordered, these are developed and by the seventh day, then, there is a—what is called a team meeting to thoroughly and comprehensively review the status of the child to determine the need for continued hospitalization, for possible alternative treatment modalities, and if hospitalization is indicated, what kind of treatment program should be developed.

[9]

Q During this seven day evaluation period, does the

staff and the units go outside of the records so far to determine whether or not hospitalization . . .

A Yes, there's always an effort to—hopefully when the child is brought in, you take advantage of—by the way, I think earlier I said the C&A staff is not involved. That's not quite accurate. Obviously if there is a parent right there, they're going to try to get hold of that parent to sit there and talk—to get as much information as they possibly can. They'll also try to contact any other people who may have been involved with this child prior to admission to see what information they can gather that would bear upon the disposition of the child.

Q What other sources might they contact?

A Well, you name it. Parents, relatives, schools, D.F.C.S., juvenile courts.

Q Would—this would be done at the initial admitting phase and then perhaps supplemented?

A They'll try to get this information as rapidly as they can. Now the fact of the matter is, of course, that you don't always get it, and the fact of the matter is that sometimes the people don't make the contacts they should make.

Q What efforts are made in your region, Doctor, to treat the family at the same time as the child is being treated?

A We do make efforts. I don't know how to quite characterize it. The fact of the matter is that many of the parents of these children are having difficulties of one kind or another [10] themselves. Some of the children, I don't really know the number of them, I guess it's a large percentage, come from broken homes and so forth, but they

do try as much as they can to get the other—get parents involved in treatment. Now what percentage of the cases this is done, I really don't know.

Q Who would have that knowledge?

A I would imagine the chief social worker might know that better than anybody.

Q And who would that be?

A Carolyn Grant.

NOTE: (Defendant's Exhibits Numbers Six, Seven, Eight, Nine and Ten were marked for purposes of identification.)

Q Doctor, if you would just identify for the record, please, what each of these exhibits is and explain how the information was derived and who did it?

A All right. Exhibit Number Six are applicants under seventeen years of age for voluntary admission who have been screened by what we refer to as our admission evaluation team, the four people I alluded to earlier, during the past roughly eight months, from April 1, 1975, to November 30, 1975. These people work during regular working hours, a forty hour week. This document demonstrates that during this period of time these people have actively participated in the screening of twenty-nine youngsters, nine of whom were not admitted to the hospital, but rather were referred to a variety of other places, community mental health centers, other regional hospitals, psycho-educational programs, and appropriate [11] community resources units or retardation facilities.

Q And where did that information come from?

A This information was put together by one of the members of the admission evaluation team, Don Harris.

Q And Exhibit Seven?

A Exhibit Seven is a summary of applicants for voluntary admission who were subsequently admitted under eighteen years of age from April 1st, '75 to November 30, '75. It shows that we had a total of seventy-one such individuals, and gives the various assignments in the hospital—that is placements, where they were placed in the hospital once they got there.

Q Okay. Who . . .

A This information was also put together by Mr. Don Harris.

Q All right. And number Eight?

A Okay. Exhibit Number Eight is a list of children and adolescents who have been discharged from Central State Hospital since 1969, giving their type commitment, case number, convalescent leave date, discharge date, diagnosis code, disposition and days in hospital. This document reflects that there were a total of seven hundred and thirty-three cases, two hundred and thirty-two of which were court admissions, one hundred and thirty-six of which were medical commitments, and three hundred and sixty-two of which were voluntary admissions.

Q By medical commitments you mean in counties that use the medical procedure for admission?

A Correct. That's right. Of these seven hundred and thirty-three people released from Central State Hospital during this period of time, the document also summarizes the fact that five hundred [12] and three of them were released to parents, fifty-four were released to relatives, forty-one were released to the Department of Family and Childrens Services, thirty-six were released to courts,

nine released to other regional hospitals, twenty-three released to foster homes, and sixty-seven released other, and I think a review of the list itself can indicate what is included in "other".

Q Okay.

A I would like to—of the three hundred and sixty-two, and there may be three hundred and sixty-one, I'm not sure, voluntary admissions—two hundred and sixty-two, is that right?

MR. GRANBERG: Three.

A Three? I believe it's—well, I don't recall. I thought I had those facts in my head but I don't have them, so I won't say anything. What I was trying to say is that the overwhelming percentage of the voluntary admissions were released to their parents or to relatives or legal guardians. But the overwhelming percentage to—directly back to their parents.

Q And number Nine?

A This is a list of children and adolescents who are currently on convalescent leave from Central State Hospital.

Q Okay. Number Ten?

A Number Ten is a list of children and adolescents who were admitted to the children and adolescents unit, and subsequently transferred to other areas of Central State Hospital, and I believe this list goes back to—transfer dates going back to at least 1969. I don't think there were any 1968's in that. [13] Can I refresh my memory by just alluding to that?

Q Yes.

A The patients on that transfer-out list who were voluntary since 1969, we had a total here listed of twenty-three. I think if you count—the source of that is a count—if you count the voluntary patients you'll find twenty-three of them who were treated in the children and adolescent unit and then reached a cut-off point and were transferred to other areas of Central State Hospital, nine of those twenty-three went to geographic units, twelve went to the Yarbrough Rehabilitation Center for specialized training, and two of them went to other areas. Of the nine who went to geographic units, as of December 1st only two are still in the hospital. Of the twelve who went to the Yarbrough Building, only five are still in the hospital as of December 1st.

Q What is the age at which they're transferred to other units?

A Seventeen years right now. When they reach their seventeenth birthday. Of the patients—I think there is thirty-eight patients listed on the convalescent leave list, I think a count will show that twenty-six of those thirty-eight children are . . . convalescent leave in the custody of their parents.

NOTE: (Brief colloquy.)

Q Yeah, this is what I was getting at. I mentioned before that the overwhelming majority of the discharged voluntary patients went to their parents, the number is two hundred and sixty-one out of the total that went back to their parents.

NOTE: (Defendant's Exhibit Number Eleven was marked for purposes of identification.)

Q If you would, identify Exhibit Eleven?

[14]

A Exhibit Eleven is a list which attempts to characterize the variety of music therapy activities provided during intervals for children in the children and adolescents unit. It also shows a memorandum from the director of the C&A unit for—for supervision for walk outs. It has a description of suggested responsibilities for big brothers and big sisters, which is generally followed. There is a behavior check list which is utilized. A memorandum from a variety of members of one of the treatment teams to the unit director saying they are going to adhere to certain guidelines for children and adolescent programs, at least quarterly preparation of a written program, monthly progress notes, written evaluation of each child's problems to be presented in the preliminary staffing, more individualized programs rather than primarily group activities, daily schedules and so on, and much of this is followed. There are, of course, exceptions.

Q In general is that document describing some of the aspects of the children and adolescent program?

A I think it's a fair, not entirely, not perfectly accurate description, but it is a fair description.

Q Does it include all aspects of the program, or just certain ones?

A That plus the earlier exhibit, I think, gives a fairly thorough idea of what goes on.

Q Once a child is admitted to the hospital, Doctor, what kind of periodic reviews are made of his case and the need for continued hospitalization?

A The teams meet at weekly intervals to discuss various cases. How often a particular child comes up for review varies from child to child, and I don't think it

would be accurate to [15] try to characterize a specified time for systematic, periodic review.

Q Would there be an outside limit?

A I would say that the overwhelming majority of the children are discussed at team meetings, their status reviewed, generally no more than at sixty day intervals.

Q Are there ever any reviews by staff members outside of the C&A unit?

A The utilization review committee periodically will try to assess how well the facility, the hospital services, are being used in trying to foster care. I think you've got some documents here which speak to that.

NOTE: (Defendant's Exhibit Number Twelve was marked for purposes of identification.)

NOTE: (Brief colloquy.)

Q Exhibit Number Eleven were different documents discussing the program?

A Yeah.

Q And in the interim there, we found another document which is an example of the case program?

A This is an example of some notes that one of the team members would make in showing the various check list elements, a narrative description, as well as specifying the date on which the child was seen by the individual filling this out, as well as during what time during the day—a half hour for example, minimum of thirty minutes a week.

Q So we're adding this to Exhibit Number Eleven. Now would you identify Exhibit Number Twelve, please?

[16]

A All right, Exhibit Number Twelve is material dealing with utilization review plans and activity.

NOTE: (Brief colloquy.)

A This total Exhibit consists of a memorandum which I sent to Mr. Charles Methvin up here in response to a request from Doctor Skelton, regarding an example of utilization review plan, and there is an attachment here with a utilization review plan of the Regional Mental Health Center of the Central State Hospital. Another part of this Exhibit is a sample of the minutes of the utilization review committee of May 6th, 1975, describing a summary of their review of eleven charts in the children and adolescent unit. And the third section of this is detailed utilization review procedures now being utilized, recently implemented, that have been approved by the Executive Committee of the medical staff, I think, back in September, have been under discussion—a special committee was appointed by me several months before that. I don't recall how long ago. This is a—procedures which list specific criteria for admission which our utilization review coordinator, who is a nurse with a Ph.D. in nursing research—that is her job. This is being used now for patients in our evaluation section, has not yet gotten to the children and adolescent unit, however it is utilized for some of the individuals who wind up in an evaluation area —our seventeen year olds. It has been used during the past—since November 1st for over a hundred cases—review cases, and there is a form here which is utilized by this individual and this material is then presented to the utilization review committee for their discussions . . .

[17]

Q And is this all—this one packet part of one process . . .

A Yes, it is essentially all the same process.

Q And these procedures are in effect right now?

A That's right.

Q And are all cases reviewed at some period?

A No.

Q Are they selected . . .

A Right now—right now we are focusing on our admissions area. This is an area that we need to develop additional strength in, so the utilization review coordinator is spending virtually her full time reviewing cases of people in the evaluation—during the evaluation period. In fact, in most cases—well, within one to five days after admission.

Q Does she also review the child and adolescent admissions?

A No, she's not doing that at the present time. She's only one person and we have a fairly high admission rate. The—as I indicated, some seventeen year olds—people between seventeen and eighteen are placed in this area, so some charts of these individuals have been reviewed. I have no idea what the number has been, but these particular procedures have not yet found their way down to the children and adolescent unit. We have only one utilization review coordinator, and that is on the drawing board at the present time. I might say that the utilization review plan describes both admission criteria review as well as extended stay review, and some extended stay review

has been done. The committee is thinking—and has been doing it to some degree at sixty day intervals.

Q Does that apply to children and adolescents?

[18]

A It will apply to children and adolescents.

Q It has not yet?

A No. Now the utilization review committee, prior to the development of these more recent procedures, as indicated in one of the attachments there, did specifically focus on the C&A in May of this year.

NOTE: (Defendant's Exhibit Number Thirteen was marked for purposes of identification.)

Q Okay, Doctor Gates, would you please identify Exhibit Number Thirteen?

A Exhibit Number Thirteen is a list of individuals under the age of eighteen emotionally disturbed and presently at Central State Hospital—in Central State Hospital as of December 1st, 1975 as well as samples of admission material on each of those sixty-three people.

Q What is included for each person?

A Okay. Now this will vary to some degree, but generally there is an admission summary, physician's admission note, a history of mental illness, social history, psychiatric examination, and any legal documents that may have accompanied those patients from the . . . was relevant.

Q Okay, Doctor, my last question, one of the contentions in this case is that judicial proceedings are necessary before admission of the child to the hospital. In your opinion as superintendent, would judicial proceedings be

necessary in every case prior to the admission of a child to the hosital?

A No, I don't—I don't think that such proceedings are indicated in every case. In fact, in my review in preparation, frankly, [19] for this deposition, the evidence that we have seems to me to clearly indicate that in the overwhelming majority of cases, there has been considerable prior involvement with a host of agencies and private providers with most of our children, which is to say that if hospitalization has not been the last resort with these youngsters, it certainly has been close to it. In my reading a sample of the materials in Attachment Twelve, and I think anyone reading it would confirm this impression, one can see a history of involvement with the mental health centers, special education programs, the Departments of Family and Children Services, the Juvenile Courts, children's homes, detention homes, private providers such as psychologists and psychiatrists, until apparently the child got to the point where all of these other resources had been pretty much exhausted, and it was felt that the only remaining option was hospitalization. Based upon the evidence which we've already presented regarding the disposition of the bulk of the patients whose parents volunteer them to the hospital, it seems clear to me that these people are concerned, that they have an on-going continuing interest in their child, that they are the ones who have finally come to the point where they feel that the best thing that they can do is try to get the child in a hospital. I say this partly because, as this can usually be seen, the majority of the children who have been released from the hospital have gone directly back to their parents.

Q Are you aware of any problem because of the reluctance of parents to take their children back home when your staff recommends it?

[20]

A I think certainly there have been cases where parents have been reluctant to take their children back home. If you have a rather hefty adolescent who is threatening to elderly parents or grandparents or youngsters in the home, who has a history of being ungovernable, there is reluctance, certainly, on the part of some of these parents to have their children come back.

Q Do you have any indication of the percentage of cases in which this occurs?

A I really do not.

Q Okay. That's all the questions I have.

EXAMINATION BY MR. GOREN:

Q Doctor Gates, you went into rather great detail in your testimony about the various sources that are contacted prior to the admission of—or upon the admission of someone to the hospital, is that right?

A Yes.

Q Why were you emphasizing it?

A I think to try to convey the effort on the part of the staff to have as much information available to them as they can about the child.

Q Why is that important?

A Obviously that the more you're aware of the history and the current environment that may effect the child's psychological state, the more you can bring to bear the resources at your disposal to effect programs which are best suited to that kid.

Q And are there many sources that are contacted in trying to find this information?

A I frankly cannot quantify that, and do not know exactly what [21] is being meant by "many". I do know that the staff down there is frequently on the phone and writes many letters requesting information.

Q How is this—do you know how this information is utilized in arriving at a decision to admit someone?

A I think the various members of a team will sit at a team meeting. Typically, it's my understanding, that one of the members of the team will be the person designated to, quote, "present the case for the child." And the various members of the team then contribute what they know about the child in order to try to figure out what's the best way to go about providing a treatment setting for them.

Q And the gathering of information on the child is very important in doing that?

A I believe it is.

Q So you would like to be assured that you have all the information available on a particular child prior to a decision to admit in non-emergency situations?

A I think I would like to be assured that we have expended every reasonable effort to obtain as much information as we can at the time that a decision of one kind or another has to be made.

Q Is it possible that because for one reason or another all the information cannot be obtained?

A Certainly it's possible.

Q Okay, is it possible that because that information

wasn't able to be obtained that it could have some effect on the decision to admit a child?

A That is possible.

[22]

Q Okay. You spoke a bit before about some parents who you felt were reluctant to take their children back into their homes, that for one reason or another they do not desire to have these children back, is that correct?

A Correct.

Q And I believe you also spoke about the concern of the hospital to try to get the family involved in a child's therapy, is that right?

A Correct.

Q Why is that? Why is that necessary?

A The child, more than a developed adult, must return to an environment wherein much of his life, much of his behavior, is directly affected by adults who have responsibility for him. He's in a developmental period, being strongly affected by his familial and social situation. It does not make sense to try to provide an environment such as one in a hospital, which does not try to cope with the reality that the child must return to.

Q What effect do family interactions have on a particular condition of the child?

A That's an awfully general question, and I would think that you could bring to bear volumes of literature in child psychiatry and child psychology to answer that in one of a million different ways.

Q More specifically, would you say that the—it is very important to understand what the mental condition of the child is to be able to understand how parents operate and what their interactions are with their child?

A I'm not sure I understand that question. Would you rephrase [23] it, please?

A Okay. Is it important to understand how the parents interact among themselves and with their child in understanding the mental condition of the child?

A I think that that information certainly contributes to some degree, to a more complete understanding of the child's psychological state.

Q In your experience, have you ever found situations where the parents themselves required psychiatric treatment?

A Yes.

Q And have you ever experienced situations where parents, because of their own psychiatric difficulties often appeared to be at odds with their children in the sense that they would blame their children for certain acts that occurred within the family setting?

A I would say that I've had personal familiarity with certain cases, not at Central State Hospital, but elsewhere, where the psychological state of the parents did not appear to be, but definitely did have some bearing upon what they might or might not attribute to the child in terms of familial problems.

Q Okay. Now when you're out gathering information to make a decision on whether or not to admit a child to the hospital whose application is being sought by his parents, who would the primary source of information about that child be?

A I would expect, in many cases, that the parents would be the major sources, primary sources, of information. However, I think that in discussing the situation

with the parents, an alert interviewer, an alert clinician would make every effort, on the [24] basis of the information presented to him by the parents, to explore and seek the permission of others to explore other sources of information. For example, the schools, private physicians, whatever other providers may have been involved with the child. Relatives.

Q But you would think the parents would be the primary source of information?

A Yes.

Q Okay. In a setting where parents, then, may have psychiatric problems, may in some instances, as you said, blame the child for certain problems within the family. Would you think, then, it's possible that parents may misinterpret or mispresent (sic) or distort facts when they're being asked to describe the behavior of their child?

A I think it's possible for anybody to distort or misrepresent the facts in any situation in which they are personally involved—or even not personally involved. One would hope that the clinician involved in such an activity would have sufficient expertise to be able to discriminate the distortion from the reality.

Q Is this often done quickly and easily?

A What do you mean by "quickly and easily," now?

Q When you have a situation in which there are complex interactions between the family and the child which are necessary to understand before a decision can be made to admit a child, is it often difficult to discover these facts that you're going to need before you can make a decision?

A I think it's sometimes quite difficult; sometimes people are transparent.

[25]

Q Okay. In cases where it's difficult to obtain the facts, and it's not an emergency situation, would it be possible that your staff would take a couple of days to try to gather all the factual information available that they could before they would make a decision on admitting a child?

A I would imagine—for example on a list of fifty-two patients who have been screened by the staff down there that there have been instances where the evaluation process had taken several days.

Q Okay. And during this several day period, where would this child be during this information gathering?

A I believe, I don't know this for a fact, because I was not directly involved with it, but I believe on the basis of the information available to me that in some of the cases, the children simply remained at home.

Q Okay. Do you think it's possible, because of the conflicts, again, that parents might not readily reveal all the information which would be important in making a decision about a child?

A That's certainly possible.

Q Would you think it would be helpful if procedures could be established so that there would be an increased chance of finding out information from parents that they would not readily reveal?

A I think the way I would answer that is to say that anything we can do to ensure the validity and comprehensiveness of the information that we have, that would contribute to a decision, would be helpful.

Q Okay. In describing—or in answering Ms. Kirkley's question [26] about is a hearing necessary in every case,

you said, "No, not in every case," that in most cases you felt there is considerable effort made to try other remedies, and hospitalization is probably close to the last resort, is that right?

A What I said was I based upon my review of samples of the materials presented there, my impression was that in many of those cases there is documentation of the participation and involvement of a host of providers and agencies prior to the hospitalization of the child.

Q Okay. But in some of those cases that wasn't evident?

A I can think of one that struck me as—one of the samples in there that I read, and I did not read them all —one that struck me that had not had a whole lot of participation by other agencies. If I recall it, the child had had a history of minor altercations with police officials, had finally, I believe, committed some kind of a more major offense, and in the rural community, the sheriff was familiar with the child and the family, and in lieu of pressing charges, the parents agreed to seek psychiatric help for the child. And I think in that case there may have been some documentation of the child having had difficulties in school, but I couldn't—it kind of stood out because it—I didn't see any other evidence of mental health clinic people or private psychiatrists or psychologists or something.

Q In this kind of situation where the child is admitted as a voluntary patient, presently there are no proceedings which a child is required to go through prior to admission, is that correct?

A No procedural—prior to the time the child gets to the hospital?

[27]

Q Yes.

A No.

Q Okay. Now is it your feeling that in cases where we're concerned about whether or not alternatives are exhausted or whether or not all the facts could be obtained to make an appropriate decision on a child concerning admission, that in those situations is it really harmful to have a hearing, let's say before some arbitrator, who would be able to check out facts that perhaps parents couldn't reveal, for instance if the parents had a history of child abuse, that may be something that they might not readily reveal, and the court could have access to that. In your opinion would that be harmful to a child?

A Could you describe for me a little bit more about how you would see such a proceeding before I answer that question, because I'm not sure that perhaps the nature of the proceedings might have . . .

Q Okay. In a proceeding where the objective of the proceeding—and it's obviously a flexible thing at this point—that the objective of the proceeding would be to discover information, all information available about a child, and to exhaust all alternatives—investigate all alternatives prior to admission in a non-emergency case. That would be the function of the hearing. Do you think that would be harmful to a child?

A I'm not sure that that in itself would be harmful. I would like to think that if a parent brings a child to a community mental health center, for example, that the staff there [28] substantially do conduct a professional hearing. And one would like to assume that—with a certain degree of expertise. As I said earlier, I think any

procedure that would contribute to the thoroughness of the information would be helpful.

Q You said, "You would think," and, "You assume." Do you know that proceedings go on in community health centers for that?

A It's my understanding that when a child is brought to a community mental health center, that the child is studied, the parents are interviewed, the case workers, social workers, try to obtain as much information from school authorities and so forth and so on.

Q But that's not a formal hearing—proceeding?

A No, that's why I said substantially.

Q Okay. Doctor Gates, when you were talking about admission procedures at Central State, I believe you said that all children, and that is persons younger than eighteen years of age who were voluntarily admitted by their parents, first go to the admission center in the Howell Building, is that right?

A No, no, no, no.

Q Where do they go first?

A The children and adolescent unit does not accept youngsters below the age of seventeen. (sic)

Q Okay.

A Generally people who are between and—who are over seventeen would go to the evaluation ward. In some cases, of course, they go directly to the geographic unit or if certain other special conditions are in effect, they may go someplace else at Central State Hospital. The youngsters under seventeen, by and large [29] go directly to the C&A.

Q Their first interview is not in the admissions building?

A Oh, no, I'm sorry. When these youngsters come to the admissions office during the regular work week, they are talked to, screened by one or more members of the admission evaluation team in the admission office.

Q Are there written procedures describing what is to be done at that first screening?

A No.

Q Do you know what, in fact, actually happens at that first screening?

A Ms. Scott, Mr. Harris, Ms. Shirley, whoever is involved, will wait until a clerk has obtained certain kinds of . . . largely administrative information, will then sit down with the—whoever accompanies the child, to try to get some idea—in fact, conducts an interview. They have used a variety of check lists, and narrative descriptions. Based upon that, if there is some question on the basis of their observations and talks with the children, say intellectual functioning of the child, they try to get a psychology technician to come down and do a very brief mental exam. After this, the admission evaluator will get with the admitting office physician and, in effect, present some recommendation as to what is felt to be more suitable. One of the exhibits there shows that during the last eight months nine of the twenty-nine people who were screened in this manner were referred to what the—the admitting office physician is the one who makes the decision, based on personal observation of the child, as well as the [30] recommendation of one of the members of the admission evaluation team. When someone, and this, of course, is true not just for children, but for anyone else,

when someone is refused admission, there is always an effort, and a largely successful effort, to refer the person to some other facility, a community mental health center, or . . .

Q When the child is accepted in this facility, do the —when the screening physician does make the decision to admit . . .

A Then the child is sent directly to the children and adolescent unit.

Q Suppose that child is diagnosed as mentally retarded, after—you said a psychologist may come down if there is some indication and do a quick test on the child, what happens to the child?

A When it seems indicated that the child is mentally retarded, the staff of the community resources unit is contacted to help assist with this physician. Since there is a very strong attempt on the part of the community resources unit, the mental health facility generally, to admit only after a pre-admission evaluation, they, in the clear cases of mental retardation, try to make arrangements for the child to be dealt with otherwise.

Q Suppose that child or adolescent is from the Rome catchment area?

A Then the mentally retarded individual will typically wind up in the children and adolescent unit, if admission is clearly indicated, until such time as he can be relocated in a Rome mental facility. In some cases the individual may be sent to DAC.

[31]

Q What is DAC?

A The evaluation ward.

Q That is where adults are evaluated?

A True.

Q Does the children and adolescent unit accept persons that are diagnosed as retarded?

A The fact is that they do despite the fact that they are not very happy about it.

Q And what happens with those persons who are sent to DAC, what happens to them?

A The majority of those, if they have to remain in the hospital, will wind up down in the children and adolescent until they can be relocated elsewhere. Some of them are also sent to some of the geographic units.

Q And those geographic units are adult wards?

A They are.

Q Okay. Now after a child is sent to the C&A—the children and adolescent unit, is that where you started describing the responsibility action format?

A Yes.

Q Okay. When was that procedure first implemented?

A Roughly November of '74.

Q That's when this was first distributed?

A That's right.

Q Now, you were also describing at one point, and I believe it was in reference to Exhibit Eight, concerning the history of the children who are admitted as voluntary patients, that two hundred and sixty-one out of three hundred and sixty-two of [32] those children were returned back to their parents . . .

A Uh-huh. (Affirmative.)

Q . . . is that right?

A (Nods in the affirmative.)

Q Which percent of those cases, do you know, were subsequently rehospitalized?

A I don't know.

Q Okay. You also testified, I believe, that at the age of seventeen that children who had been on the adolescent ward or adolescent unit, were then transferred to adult wards, is that correct?

A That's right. I believe there's an exhibit there that describes twenty-three such individuals.

Q Okay. Isn't there also a policy in the C&A unit that —let's say, for instance, a person who is admitted there was pregnant or has a child, that they would be transferred to an adult ward?

A There has been such a policy.

Q Okay. And that is irregardless of the age of a person?

A The youngest that I'm aware of was thirteen.

Q And that person was placed on an adult ward?

A I know the patient was placed in the Jones Building for some period of time, and I think that person was also placed for some period on an adult ward.

Q Okay. Is that policy still in existence?

A Yes.

Q Now, you were also discussing—excuse me. Is there a certain [33] standardized manual that is referred to in diagnosing children or adolescents upon their admission?

Is there a manual that's used to place a child in a particular . . .

A The Diagnostic and Statistical Manual.

Q Number?

A Two.

Q Okay. Do you know which percentage of the children admitted—volunteer children by their parents, who were admitted in the particular categories listed in the Diagnostic and Statistical Manual Number Two?

A Yes, I do. Of the three hundred and sixty-one or two voluntary patients listed on the Exhibit Number—whatever it is . . .

Q Exhibit Eight?

A Exhibit Eight, the count there revealed that fifty-three had a diagnosis of mental retardation, fourteen diagnosed as a organic brain syndrome of one kind or another, forty-two were diagnosed as a psychoses not attributed to physical conditions listed previously, twenty-five a diagnosis of neurosis of one kind or another, twenty-five a diagnosis of personality disorders and certain other non-psychotic mental disorders, three, a diagnosis of psycho-physiologic disorders, zero had a diagnosis of special symptoms, one hundred and thirty-two had a diagnosis of transient situational disturbances, sixty-one had a diagnosis of behavior disorders of childhood and adolescence, ten—no four had a diagnosis of conditions without manifest psychiatric disorder and non-specific conditions, and two had a label of non-diagnostic. . . .

[34]

Q Okay. You said there was a hundred and thirty-two transient situational disturbances?

A Correct.

Q How is that defined?

A This is a class of disturbances encompassing adjustment reactions of childhood, adolescence, young adult life and later adult life.

Q And it seems, basing the figures that you gave us, that those are by far the majority of the categories?

A They account roughly for one-third.

Q One-third. Are there more diagnosed in that category than any other?

A Yes.

Q And now—what is the nature of that kind of diagnosis? Is that a severe impairment, is it psychosis, could you describe that, please?

A I think it's fair to say that it is a diagnostic category which is used to describe a very wide variety of deviant behaviors in children, which behaviors are frequently felt to be a function of the child's social situation, the environmental stresses to which he is exposed, coupled with whatever developmental events may have occurred.

Q Okay. Is that considered a—are those considered psychotic disorders?

A No.

Q How severely disabling would those disorders be?

A I think that the only—one cannot answer such a question. There is an enormous variation.

[35]

Q So it could run from mild to severe?

A Yes.

Q Okay. Concerning the periodic reviews that you were describing, I believe you said the treatment teams meet weekly to discuss various cases?

A That's my understanding, that's right.

Q Not every case is discussed . . .

A No, no, no. Definitely, I did not mean to convey that impression.

Q How are these—what are these, random reviews?

A I'm not familiar with the procedures by which they schedule . . . patients.

Q Do you know how these reviews are conducted, what they consist of?

A It is my understanding that there is a discussion by the primary therapist and the other members of the team who are involved with the child, his current status in comparison programs with . . . his status since an earlier review, a provision of any additional information that may have been obtained regarding where the parents are, the social situation, the family life to which he eventually might be returning, any additional progress with respect to financial, legal, whatever matters that may have effected the child's hospitalization in the first place.

Q Is there a member on that committee who does have legal training?

A No, there isn't. No one who has clearly identified legal training, although it's hard for professional people to function [36] in a psychiatric hospital these days without some awareness of legal matters. (Laughter.)

Q Okay. Do you know how these team meetings are conducted, who leads them, how decisions . . .

A I think that's varies. I think that varies. I do not typically attend such meetings.

Q You also discussed utilization review committees?

A Yes.

Q That's in Exhibit Twelve. Could you just briefly describe how those are conducted and who participates in them?

A I would really prefer not to comment on that myself since I do not participate in utilization reviews. Doctor Smith and other members of the medical staff as well as certain other professionals routinely do.

Q I believe you also said the utilization review committee also, as the periodic that you previously described that were done every week, are done on random cases, is that right?

NOTE: #947

A I think it's fair to say that that has traditionally been the case.

Q I think you also said that one review was done in May of this year, of the C&A unit?

A That's true. There's an attachment to the exhibit.

Q Do you know why that was done?

A No. I would just assume that the committee felt it was timely and opportune to conduct such a review. The committee—I think I can say that the committee has moved from unit to unit, and those minutes, for example, point out that the next meeting would be held in Veterans.

[37]

Q Okay. And I believe you also said that the policy does not yet apply to the childrens unit specifically, that is that they do not do periodically . . .

A No, I think you misunderstood me.

Q Okay.

A The plan, that mode of operation for utilization review, does apply as is evidenced in the minutes of the May 6th meeting. What I was saying is that we have not yet gotten to the children and adolescent unit with our more recently developed, explicit criteria, that a utilization review coordinator utilizes.

Q Okay. Now, is there any periodic review, or any review that's done every so often in a specified time which would review the case of every child within the C&A unit?

A As I said earlier, the staff in the unit at their regularly scheduled meetings, by virtue of the various progress notes that they make and so on, does conduct in a sense, on a rather routine basis, periodic review of various cases. Now if you're asking me is there any directive which says that every case will be reviewed every thirty or sixty days, I would have to answer no.

Q Okay. In the last year do you know how often the utilization review committee has reviewed random cases in the C&A unit?

A I do not know.

Q Okay. Doctor Gates, what would be the effect, do you think, if at these reviews, when they are conducted, that the information that you say is gathered, the study of the present mental status and past mental status of a

patient, if that information were submitted to, say, a psychiatrist outside of the unit, who is [38] independent of the hospital, say, for his review, do you think that would be unduly burdensome on the review process?

A No. As a matter of fact, the utilization review plan, which is part of the Exhibit here, specifically mentioned that a physician or psychiatrist should not participate in the utilization review in cases for which he is directly responsible. The composition of the utilization review committee is a rather broad one, so it is possible to conduct the utilization review in that fasion.

Q Okay, but . . .

A In effect you wind up with outside professionals looking in on the work of others.

Q And you believe that to be beneficial?

A Yes.

Q Why?

A I think any time any of us can get feedback and evaluation from our peers, it can only serve to improve our performance.

Q Okay.

A I would assume that the same would be true of attorneys as well as psychologists and psychiatrists.

Q Is it also discussed at these reviews, alternatives to hospitalization? Whether or not they would be appropriate and what alternatives are available?

A Yes, I believe—I believe that if you'll read the sample of the utilization review committee report, you will see a question is raised there on that one particular case with respect to alternatives.

Q Okay. What effect do you think it would haveon this review [39] process if the findings of the review and the facts of the review were submitted to an independent arbitrator, someone who is independent of the system, to review and search out alternatives and to compile the facts and make a review based on what has been submitted to him?

A Le me be sure I understand what you are saying. What effect would it have if an independent arbiter were to do this kind of utilization review?

Q Yes.

A I don't know. What possible kinds of effects are you . . .

Q You said, for instance, that if someone who wasn't involved in the treatment team, if they could give their opinion on what needed to be done, that could be really helpful. Okay, I'm just taking that a step further. It it was someone who was not a person who would review it like that, but someone who was outside of the system who would examine all of the information and search out alternatives, if that also would be helpful in the same sense of submitting the information to someone outside of the treatment team for their opinion?

A It might and it might not. I think—one would like to think that in such a utilization process, what you're doing is bringing to bear the judgment and experience of peers—professional peers, who do not have a particular interest in a case one way or another, and who have a capability within the framework of not being liable, or not being punitive, to give honest feedback, unless one assumes that such reviewers, who would be members of the staff located elsewhere in the facility—or unless one

assumes that the staff themselves have no interest in [40] seeking alternatives.

Q I'm not talking about those kind of assumptions, because I assume that everyone does really do their best to try to find it, but unfortunately—let's talk about this. Do you feel like your staff has large case load problems?

A Do I feel like that our staff is worked to the limit?

Q Yes.

A Yes.

Q Okay. And because of that, because you feel that they're worked to the limit, is it possible that because of that work load they may not be able to check out all the alternatives?

A That is certainly possible.

Q And if there was someone else outside who had the time and who had the experience and who had the where-withal to check those out, wouldn't that be beneficial?

A I'd like to think that our community liaison people do precisely that, and rather than a person be completely outside of the system, I'd rather have them on the staff.

Q But is that, in fact, what happens? I mean do those outside people participate in these reviews?

A They sure do. Our staff is routinely on the phone, or writing letters . . .

Q No, but I mean are they there at these periodic meetings?

A Generally not.

Q Okay. How would you feel if, at these reviews, the child or the adolescent were represented by an advocate,

and not an advocate who would disrupt the proceedings, but someone who would be there solely to present the interests of the child or [41] the adolescent, someone to explore all of the considerations in his behalf, to add his input to the review process?

A The only real way in which I would tend to think that would be beneficial is if one made the assumption that neither the parents or legal guardians or the staff had the same kind of interest.

Q As far as . . .

A I would like to think of our staff as being the advocates for patients.

Q Sure. Is that always the case? I mean, you've described . . .

A I'm sure there are exceptions.

Q Okay. Doctor, now I'd like to ask you some questions concerned about the staff—the staff in particular at Central State. Do you know which percentage of—well, let me ask you first, how many physicians are there at your facility?

A There are roughly a hundred physicians at Central State Hospital.

Q Do you know which percentage of those physicians are board certified psychiatrists, or how many are board certified psychiatrists?

A Three out of a hundred.

Q Do you know which percentage or how many of those physicians are board eligible psychiatrists?

A Approximately twenty-two.

Q Do you know how many or what percentage of those physicians are licensed M.D.'s?

A All are.

Q Okay. I mean licensed M.D.'s as opposed to being board certified or board eligible psychiatrists.

[42]

A Oh. Well, several of the physicians that I'm—I have very little contact with are members of other specialties, so I really can't comment on that.

Q Do you know which percentage or how many physicians at your facility are only licensed to practice in state institutions?

A I do not have the number at my fingertips, but we do have several in that category.

Q Okay. Are there any board certified or board eligible child psychitrists at . . .

A We have one board certified child psychiatrist.

Q And where does that person work?

A In the Dublin geographic unit.

Q Is that the children and adolescents ward?

A No.

Q That's an adult ward?

A It is.

Q Does that child psychiatrist have any cases from your children and adolescent unit?

A He has been asked to consult with certain cases, but he does not as a matter of routine work in the children and adolescent unit. I might mention that this man is

relatively new in the facility, and is working in an area now where the previous psychiatrist died.

Q Wasn't he assigned to that unit two days before that doctor died?

A He was, and the intent was to rotate this particular man through all of our regional division units including the children and adolescent unit.

[43]

Q Isn't that—is there also another doctor at the facility who is in training for certification as a child psychiatrist?

A No, he has passed part of the examination for certification in child psychiatry and is studying to take the remainder of that examination.

Q Where does he work?

A He works in the Metro-Atlanta adult unit.

Q Are there any foreign born or foreign trained physicians at your facility?

A Yes, there are.

Q Do you have any idea what percentage or how many there are?

A The number of foreign medical graduates is large. I don't know what the number is. It's over fifty percent.

Q And do any of these physicians have any difficulty with the English language?

A Some of them do.

Q Okay. Do any of these physicians participate in the admissions process?

A Yes.

Q Do any of these physicians participate specifically in the admission process for children and adolescents?

A Yes.

Q In your opinion is it important to be able to fluently understand the language of the child or adolescent that you're diagnosing in order to arrive at a valid diagnosis?

A It's certainly important to be able to communicate —with not only the child, but certainly also the parents of the child.

Q Doctor Gates, are you familiar with the report of the Study [44] Commission on Mental Health Services for Children and Youth published on November 9th, 1973?

A Yes, I am somewhat familiar with it.

Q Okay. Before we go into that a little more, could you describe how the units for children and adolescents are set up at your facility? Is there one facility . . .

A There is a separate building for children with a capacity of roughly forty beds. There are two wards in the . . . Building, one for male adolescents and one for female adolescents.

Q And as to that adolescent unit, this report arrived at a conclusion and recommendation based on that facility, and I guess you agree with that conclusion?

A Would you refresh my memory, please?

Q Yes. The conclusion said, "Plans should begin now for closing the eighty bed adolescent unit. It is a physical facility completely unacceptable for therapeutic rehabilitation of young people."

A I generally agree with the concept that it is not the most conducive physical facility. We are, in fact, presently making plans to move adolescents from that area. Such plans, I might add, that have been under active discussion for some period of time.

Q There is also another recommendation in that it's —and I'd like to ask you if you agree with this, "That it is essential that the new regional hospitals begin children and youth services as soon as possible, and children and youth at Central State and geographic areas . . . hospital services to be transferred."

[45]

A Basically yes, and I think it's fair to say that that has certainly been the effort of our staff.

Q But I believe you did describe that children from the Rome area are still residing at Central State?

A That's correct.

MR. GOREN: I would like to note for the record that Doctor Smith has stated that the utilization review committee has reviewed random cases in the child and adolescent unit once in the past year.

EXAMINATION BY MS. KIRKLEY:

Q When Mr. Goren was asking you questions, he asked you if there were some foreign born or trained doctors who had difficulty with the English language and you said that there were. Are there any such doctors who have difficulties with the English language who work on the children and adolescent unit?

A There are two native Spanish speaking physicians on that unit. I personally have no difficulty understanding them. My observation is that they are able to generate

good rapport and communication with the children and adolescents.

Q That's all I have.

EXAMINATION BY MR. GOREN:

Q Did you notice that other people might have difficulty understanding them?

A Yes, I would think it fair to say that some other people might.

Q And do you think it's possible that they might have some difficulty in communicating with other people?

A I'm sure that's the case on occasion.

[46]

Q And who are those doctors?

A Doctor Zapatero and Doctor Bejarno.

END OF DEPOSITION

* * * * *

[1]

ATTACHMENT
EXAMPLE of
Admission Program
In Responsibility-
Action Format

I. PRELIMINARY SCREENING: Prior to consideration for admission, the referral agency shall contact the staff of the children's building concerning the preliminary screening procedure. No child will be admitted to the children's unit without first receiving or having had a recent psychological evaluation including the WISC, Bender and one projective test (preferably Blacky series or sentence completion test). Historical and background (family, medical and social) data must also be provided whether through family interview or agency records. The staff in consultation with the referring source will determine exhaustion of community resources; if hospitalization is recommended, an explanation of the treatment program and tour of the building will be provided to acquaint the source with the physical treatment setting. It shall be imperative that a contracted agreement defining the roles and responsibilities of both parties be drawn up and signed. (Copy of this contract is attached to this document.)

Due to the requirement for a preliminary screening, no child shall be admitted after 5:00 p.m., or on weekends or holidays.

II: ADMISSION TO THE WARD

PURPOSE: To admit the patient to C & A Unit in a routine manner which will achieve the following objectives:

Gates Defendant's Exhibit Number Four
JMW 12/4/75

1) Involve the patient immediately in therapeutic relationship and routines with Unit staff.

2) Assure prompt and orderly initiation of all admission procedures.

3) Provide for the planned collection of information necessary for beginning assessment and treatment of the patient's situations.

4) Assure prompt involvement of community and family resources in diagnosis and treatment of the patient's situation.

[2]

III. PARTICIPATING PERSONNEL: Unit Receptionist, Admission Ward R.N., Physician, Admission Ward Charge Attendants, staff persons assigned to interview the patient's family, Admitting Attendant and psychologist (see above).

RESPONSIBILITY	ACTION
Unit Receptionist	1) Courteously seat patient and escort to appropriate area while awaiting admission ward personnel
	2) Notify receiving ward of patient to be admitted.
R.N. (Charge Attendant in R.N.'s absence)	1) Assign Admitting Attendant
Admitting Attendant	1) Meet patient and family in lobby and introduce self in friendly manner.

	2) Take patient's luggage and escort him to ward receiving area, explaining the immediately impending events. 3) If there are relatives, escort them to visitor's room, and inform R.N. (or Charge Attendant).
R.N. (Charge Attendant in R.N.'s absence)	1) Inform appropriate physician of patient's arrival. 2) Assign Big Brother or Sister for each shift. 3) Immediately upon coming on duty, check admission book for emergency admission patients admitted since 5:00 p.m. of the last working day, review patient's condition, and inform appropriate physician.
Admitting Attendant	1) Obtain temperature, blood pressure, height and weight, give admission bath and complete clothes list, money sheet, and nurses admission assessment.
Physician	1) See patient as soon as possible to conduct appropriate preliminary examinations, prescribe medication as indicated, order laboratory studies, and write admission note (if not done in Powell Building). (If patient was seen in Powell Building, review and prescribe medication, if necessary; order supportive lab work and additional examinations.)

Psychologist	1) Determine needs and course of treatment for the patient in conjunction with Big Brother and Sister. 2) Inform attendant staff of any specific restrictions or privileges the child might require (in conjunction with Big Brother and Big Sisters). 3) Implement course of therapy with attendant and nursing staff.
Admitting Attendant	1) Orient patient to physical ward structure—dining and bathing facilities, sleeping areas, dayrooms, etc. 2) Stress supportive reassurance to patient, alerting him to routine events of next few days—lab work, Preliminary Evaluation Meeting, etc. 3) Give patient prepared Orientation Material (see attached), explain basic ward structure, rules and regulations. 4) Discuss briefly Big Brother or Sisters role while reminding patient he will meet them tomorrow. 5) Introduce patient to ward staff and a few appropriate patients. 6) Leave patient with other patients, or in his room. 7) Complete Kardex Card, Nurses Admission Notes, and Notification of Admission. 8) Complete routine lab work slips and place in designated place for R.N.

[4]

Admission to Ward

INITIAL EVALUATION MEETING

PURPOSE: The Preliminary Evaluation Meeting is designed, as is the entire admission process, to utilize the limited information available, including staff observations, to activate all appropriate Unit resources as quickly as possible on the patient's behalf. Objectives of the Preliminary Evaluation Meeting are:

1) To provide an early formal review of the patient by key members of the treatment team. The review will be accomplished on the (7) seventh day following admission.

2) To identify, prescribe and immediately involve the patient with the treatment resources relevant to his situation.

3) To enhance the patient's adjustment to the treatment situation by providing greater familiarity with the members of the evaluation team, and with the activities planned for him during the evaluation period.

4) To arrange for the orderly gathering of information essential to treatment planning and/or disposition.

5) To identify, prepare for, and schedule necessary Forensic Staffings.

PARTICIPATING PERSONNEL: Physician, R.N., 7-3 Charge Attendant, Primary Therapist, and Team Leader. Big Brother & Sister, Psychologist, Music Therapist, Recreation Therapist, and School Representative.

Admission to Ward

RESPONSIBILITY	ACTION
Team (R.N., Charge Attendant, Big Brother or Sister (if any on day shift), Physician Team Leader).	1) See all new patients in the first working day following admission allowing ten to fifteen minutes to each patient for introduction to the Preliminary Evaluation team members, initial evaluation assignment to beginning therapeutic activities, and specifications of additional information required for further planning. 2) On patients with Court Orders, determine additional information required for staffing and set deadlines for this to be obtained.
Physician	1) Write necessary orders.
R.N.	1) Remind team members of meeting.
[5]	
R.N. or delegate	1) Bring charts to meeting
Big Brother or Sister	1) Provide any preliminary supplementary information concerning ward behavior.
Team Leader	1) Familiarize himself with historical date. 2) Conduct meeting. 3) Complete Preliminary Evaluation Form on each patient following recommendations of team. (See attached) 4) Consult with physician regarding the need for Forensic Staffing of each Court Order, set date for staffing, notify Unit

Director's Secretary and inform attending physician at Disposition Meeting.

5) Assume responsibility for seeing that all activities assigned on the patient's behalf are transmitted appropriately and performed.
6) The Team Leader may delegate portions of (4) above to R.N. or Charge Attendant.

[6]

BIG BROTHER OR BIG SISTER DUTIES DURING EVALUATION PERIOD

PURPOSE: To routinely establish a structure for each patient through which the ward's primary therapeutic objectives are obtained. These objectives are:

1) To assure that each patient has one staff member who is primarily responsible for his general well-being and basic progress on the ward.
2) To provide each patient with a consistent, frequent, regularly scheduled therapeutic relationship with at least one ward staff member.
3) To insure that at least one ward staff member becomes sufficiently familiar with each patient to provide reasonably accurate information regarding the patient's background, his present condition and his interaction with the hospital environment.
4) To insure that a specifically designated individual is responsible for communicating information from the patient to the treatment team, and from the team to the patient.

PARTICIPATING PERSONNEL: Primary Therapist, R.N., and Team Leader

RESPONSIBILITY	ACTION
Big Brother and (B.B.) Big Sister (B.S.)	1) Within one-half hour after reporting for duty each day, check B.B. and B.S. assignment for patients admitted the previous day. 2) If a new patient has been assigned immediately find patient and spend 10-15 minutes getting acquainted. 3) The B.B. or B.S. from both the 7-3 and 3-11 shifts will attend the evaluation sessions (at 2:00 p.m.) for each of their children each day. 4) Spend at least 45 minutes a day with each assigned patient during the Evaluation Period. 5) Consult with the Team Leader or Assistant Team Leader every other day for general suggestions and directions.

[7]

6) Record a nurses note daily on each patient during Evaluation Period. These will primarily summarize B.B. and B.S. patient interaction during the day, and note any unusual observations.
7) By the end of the evaluation period (7th day), a progress note must be written in the nurses notes on each patient in Evaluation. (See attached

Admission to Ward	guideline). This note summarizes the B.B. or B.S. impressions of the patient and gives recommendation for disposition. 8) If B.B. or B.S. is scheduled to be off on the day of evaluation, write summary on his last working day before Evaluation and Disposition Meeting and place in Team Leader's basket.
R.N. or Delegate	1) Immediately following Daily Ward Management Meeting, pull charts on all patients in Evaluation Period for Team Leader's review.
Team Leader and Assistant Team Leader	1) Consult with B.B. or B.S. at least every other day during the Evaluation Period. 2) Review charts on all patients in Evaluation Period each day. 3) Insure that B.B. or B.S. completes Final Summary prior to Evaluation and Disposition Meeting. 4) Enter notation on check list when B.B. or B.S.'s final summary is written.

[8]

EVALUATION AND DISPOSITION MEETING

PURPOSE: To provide for specific planning for each patient based on the previous collection of available and essential information. Objectives are:

1) To assure compliance with the Mental Health Law in transfer from Evaluation to Treatment status.

2) To promptly identify those individuals who do not require hospitalization and to arrange for their release.

3) To promptly identify those patients who can best be treated in different settings, and to arrange for their transfer.

4) To identify those patients for whom treatment on the ward is both desirable and feasible.

5) To assure that each patient's presence on the ward is in keeping with specific, individual plans.

PARTICIPATING PERSONNEL: R.N., Physician, Big Brother or Sister, Team Leader, Assistant Team Leader, Psychologist, and Social Worker.

RESPONSIBILITY	ACTION
Team Leader & Assistant Leader	1) Insure that all information required for the meeting is in the chart at the end of the 6th working day—B.B. or B.S.'s progress note, nurses and doctors admission notes, mental examinations, assessments from involved adjunctive therapist report of family contact, and social history and psychological if ordered and available. 2) Notify R.N. of patients to be presented.
R.N. or Delegate	1) Insure that charts are pulled and patients available for meeting.
Physician and Team Leader and Assistant Team Leader	1) Review all available information on each patient. 2) Make a decision regarding disposition from the following alternatives for each patient:

	A. Assign to ward intensive treatment programs. B. Transfer within unit.

[9]

Physician and Team Leader Assistant Team Leader	2) E. Place on Convalescent Leave. F. Discharge. G. Hold for specified time and then release H. Specify further information to be obtained and defer decision to specified date.
Physician	1) Write orders necessary for above disposition.
Team Leader and Assistant Team Leader	1) Record disposition on Preliminary Evaluation Form. 2) Initiate action which will result in the disposition being carried out, and designate deadlines. 3) Schedule patient for team meeting if patient is assigned to ward intensive treatment program.
Big Brother and Sister	1) Check patient's chart to find recommended disposition. 2) If patient is assigned to ward intensive treatment, begin to function in treatment role of B.B. or B.S. 3) Begin preparation for presenting patient to team meeting.
R.N.	1) Insure that B.B. or B.S. performs above.
Team Leader	1) Initial and date disposition orders when disposition is carried out.

	2) Consult with B.B. or B.S. about treatment role with specific patients assigned to intensive treatment program.
Psychologist	1) Present psychological data and test results.
Social Worker	1) Present social, family and medical background.

[10]

Admission to Ward

WARD AND TREATMENT TEAM MEETINGS

PURPOSE: To assure that all appropriate staff members are involved in these three major functions—program development and review, treatment and disposition of individual patients, and ward management. The first two functions are accomplished at the Weekly Team Meeting; the third is met by the Daily Ward Management Meeting. Objectives of the Ward Treatment Team as a whole are:

1) To insure that each staff member is aware of all ward objectives, and of his role in ward efforts to obtain these objectives.

2) To insure coordination of all ward-related functions.

3) To provide for participation by each staff member in the development and management of all ward-related activities.

4) To develop, implement, and review individual treatment plans.

5) To develop, modify, and coordinate ward treatment programs.

Admission to Ward

6) To provide for discussion and resolution of problems related to ward management, and to general and individual patient care.

PARTICIPATING PERSONNEL: All ward staff and, periodically, all personnel involved in ward activities participate in the Weekly Team Meeting. All ward staff participate in the Daily Ward Management Meeting.

RESPONSIBILITY	ACTION
Weekly Team Meetings (All Ward Staff) Major Function One (Monday—2:00 p.m.)	1) Meet weekly, 7-3, 3-11 shifts. 2) Discuss relevant general information, including general and specific aspects of ward programs and other items related to overall ward functioning, and make recommendations regarding identified problems. 3) Hear reports from adjunctive therapies related to general and individual patient care and make recommendations regarding identified problems. 4) Discuss the response of individual patients to treatment, and recommend appropriate changes in treatment plans.

	5) Discuss specific problems and needs of individual patients related to daily living, and make suggestions for correction.
Team Leader and Assistant Team Leader	1) Meet briefly with R.N. and Charge Attendant prior to team meeting to discuss material to be covered. 2) Initiate brief discussion about specific patient management

Admission to Ward	problems, including walkouts and other privileges. 3) Notify staff of impending irregular events. 4) Following meeting, initiate or delegate any action arising from meeting.
R.N.	1) Insure staff attendance. 2) Announce daily census, previous day's patient movement, and patient movement scheduled for present day. 3) Inform treatment team of previous day's serious incident.
Charge Attendant	1) Announce individual staff assignments for the day.
All Staff	1) Briefly impart information necessary for the daily management of treatment for specific patient. 2) Discuss walkouts and other privileges for assigned patient.

Physician	1) Sign necessary orders for implementation of recommendations.
Team Leader and Assistant Team Leader	1) Insure implementation of recommendations approved by physician. Responsibility for this may be designated to other team members.
(All 7-3 Ward Staff & 3-11) Major Function Two: Treatment Planning (Mon.—8:30 & 3:30)	1) Formulate individual treatment plans for each patient assigned to intensive treatment programs at first 7-3 team meeting following disposition meeting. (See attached Treatment Plan Form.)

Admission to Ward

Physician	1) Write orders necessary for implementation of treatment plan.
R.N.	1) Insure attendance of all ward staff. 2) Insure preparation by all B.B. or B.S. presenting patients.
Big Brother or Big Sister	1) Pull Chart on patients he is presenting and have patients available. 2) Present background information necessary for treatment planning, reasons for hospitalization, precipitating factors, family situation, his general evaluation of the patient, etc. 3) Recommend treatment approaches.
Team Leader and Assistant Team Leader	1) Insure appropriate participation by all team members in treatment planning. 2) Complete Treatment Plan Form for each patient and insure inclusion in ward charts within two days after patient is presented for treatment planning. 3) Insure implementation of all treatment recommendations.
School, Recreation and Music	1) Add pertinent material
Daily Ward Management Meeting (All 7-3 ward staff & 3-11 shift) Major Function One	1) Meets 15-20 minutes daily at 8:30 a.m. and 3:15 p.m. regarding various aspects of ward management.

RELEASE PROCEDURES

Release may be initiated by the agency, facility or parent. If initiated by CGRH, notification will be given 30 days prior to release, so that pre-release conferences can be arranged with the parent or agency in which methods for handling the child can be discussed to insure continued success. Suggestions will be given concerning local resource agencies to assist in after-care.

In addition:

1. Medical information will be supplied upon request of the attending community physician.
2. School records and recommendations may be obtained by contacting: John Rawlins, Principal, School of Special Education, Central Georgia Human Resources Center, Milledgeville, Georgia.
3. Psychological information concerning recommendations for after-care will be provided for the community mental health facility responsible for after care. Additional information may be obtained by contacting J.T. Harris, RRL, Director, Medical Records Department, Central Georgia Regional Hospital, Milledgeville, Georgia.

Should release be initiated by either the admitting agency or parent, we ask that the request be made at least a week in advance to allow us time to make the necessary arrangements pertaining to medication and mandatory paperwork.

If the parent or agency is insistent upon release despite staff recommendations against such action, release Against Medical Advice will be arranged. In the event, the child will not be readmitted on a voluntary basis to CGRH.

RICHARD M. HARDEN/Commissioner
T.M.(JIM) PARHAM/Deputy Commissioner
GEORGIA DEPARTMENT OF HUMAN RESOURCES
CENTRAL GEORGIA REGIONAL HOSPITAL
on the Campus of
CENTRAL STATE HOSPITAL
Milledgeville, Georgia 31062

The following is a list of therapeutic activities sponspored and co-sponsored by the Music Therapy Department in the Children and Adolescent Unit (Past and Present). They provide structured environments for social interaction, environmental and interpersonal, as well as opportunities for stimulating certain appropriate behaviors needed by our individuals.

ON CAMPUS * = Not currently in Progress

Social Hour* Every other week
Square Dance* Every other week
Social Dance* Every other week
Choir—Once a week
Sunday Choir Performances—Approximately 8 times a year
Guitar Lessons/Group and Individual—Once a week
Drum Corps—Once a week
Piano Lessons—Once a week
Music Appreciation* Once a week
Creative Expression Groups—Twice a week
Various Recreation Activities (Pool, Ping Pong, Arts and Crafts, Volleyball, Football)—Unscheduled throughout year
Walks—Unscheduled throughout year
Trip to Circus—Once a year
Talent Show/Rehearsals, Performance/Film Show—Once a year
Birthday Parties—At appropriate times

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Christmas Party—Once a year
Valentines Party—Once a year
Halloween Party—Once a year
CHRISTMAS PAGEANT ACTIVITIES/Practice, Dress Rehearsal, Performance—rehearsals twice weekly a month before Performance
Groups—Music Exploration I and II, Music Crusaders I and II
Children's Choir—Once a week All Groups held once or twice/week
Individual Lessons, Guitar, Piano, Autoharp, Xylaphone, Flutophone, Ukelele—once a week
Special Drum Lessons, Central Music Therapy* Once a week
Children's Special Hour* Once a week

HOSPITAL ACTIVITIES ON CAMPUS Scheduled throughout year

These are activities just held in 1975!
Atlanta Symphony Concert
Warner Robbins Air Force Band
Barry College Concert
Lee High Singers
College Park High Concert
Atlanta Ballet
Organ Concert
Radcliffe Dancers
Youth Choir from Knoxville Tennessee

OFF CAMPUS

Reward Activities—to dinner at Central Kitchen, Breakfast, Lunch, Dinner, Shakey's, Dairy Queen Average 1 individual every two weeks; Choir—every week; Group—3 times a year

OFF CAMPUS (CON'T)

Overnight Visits* Once a month in past
Madrigal Dinners—Once a year
College Concerts—Whenever possible—In past 3 times a year
"10 Mile Walk" for Retarded Citizens—Once this year 1975
Six Flags Visit—Once a year
Ice Capades—Once a year
Baldwin County Fair—Once a year
Movies Hatcher Square—Periodically throughout year
Halloween Trick or Treat—Once a year
Holiday visits overnite*
Community Concerts at Georgia College—3 times a year
Programs and parties at various churches*3 times a year
Motor Cross in Macon*Once a year
Calloway Gardens*Once a year
Brown's Crossing*Once a year
Teen Club-varied home activities—crafts, cooking, socialization*Once a week
College volunteers/parties*
Swimming, fishing, picnicing—During Summer months
Special Olympics*Once a year
Jackson 5 Concerts*Once a year

[3]

RICHARD M. HARDEN/Commissioner
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GEORGIA DEPARTMENT OF HUMAN RESOURCES
CENTRAL GEORGIA REGIONAL HOSPITAL
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Milledgeville, Georgia 31062

September 26, 1975

MEMORANDUM

TO: Ward Personnel

FROM: Odilia Z. Gutierrez, M.D.

SUBJECT: Patient Care off Ward

In accordance with a memo dated 9-8-75 the following guidelines will be followed:

Children may be taken to the store and for walks in your role as big brother and big sister when you feel this is therapeutic.

A group of children may be taken for walks on the hospital grounds, to the pecan grove, playground, and outside the building when adequate supervision is provided. These groups going for a walk shall not exceed 5 children per attendant. If more than 5 go, two attendants have to go. For off campus trips or trips involving transportation in cars, an individual doctor's order will continue to be necessary.

Please continue the safeguard of making out two lists and frequently checking the patient during the outing and account for everyone upon returning to the ward. Continue to leave a list on the ward and take one with you.

Since the welfare of the children is our responsibility and priority, please observe every safeguard for their welfare.

/ag

[4]

SUGGESTED BIG BROTHER AND BIG SISTER RESPONSIBILITIES

The following outline is intended as a means of specifying the roles and responsibilities of Big Brothers and Big Sisters.

Some of the objectives for this program include:

1) Insuring that each patient receives personalized, individual attention by a member of the ward staff.

2) Keeping a written record of patient needs, progress, and treatment goals.

3) Involving all members of the ward staff as a vital, essential member of the treatment team.

Suggested Responsibilities

I. Spend at least a total of 30 minutes each week with an assigned patient.

   a. Scheduling a consistent time on specific days will help you keep your commitment and let your patient know that there is a specific time set aside for his welfare. Barring emergencies and clinic appointments, etc., you should be able to meet with your assigned patients.

   b. How you spend your time together is not as important as the fact that you are together. Nevertheless, there are several things you should look for while you are with your patients. The following points should be considered throughout your relationship with your patients—before you decide how to help him and while you are interacting with him.

   1. Assess his self-help skills.
      Does he help on the ward?

   2. Evaluate his inter-personal relationships.
      Does he initiate conversation? Does he answer questions coherently? Does he fear others? Is he aggressive, withdrawn, combative, or does he approach people only when he "needs" something?

   3. Make observations on his thought processes.
      Is he oriented to place and time, is he coherent, confused, does he know why he's here, does he have plans for his future?

   4. Determine what activities and privileges might be therapeutic for him, what new programs might be initiated for his treatment, and what possible release plans might be appropriate.

   c. Once you decide what he needs, you can begin to determine how to spend your time together. Suggested activities include:

[5]

   1. Take him off the ward—outside, to the store, to the cafeteria, home with you, on special trips, etc.

   2. Talk to him—talk about anything that might be of interest to him.

   3. Play games with him, encourage him in his academic endeavors—find his difference and proceed from there.

   4. If you feel your patient has a specific behavior problem you want to deal with, contact Mr. Coron or discuss the problem at the team meeting so that a specific program can be arranged for your patients.

II. Fill out a short behavior checklist on your patient each week. The behavior checklist will keep you aware of the changes in behavior that may not be noticed by other staff members. Your notes should include any

observations which might prove helpful to the team in assessing his condition.

III. Write a brief monthly summary on your patients' progress. This should include information from your weekly behavior checklists and any other observations concerning the patients. It should also include the long behavioral checklist.

/th

[1]

ADMISSION REVIEWS: Admissions of all Title XVIII and XIX (Medicare and Medicaid) patients and other patients as described elsewhere in this Plan shall be reviewed within one working day of admission except that, as determined by the Committee, cases of certain physicians or with certain diagnoses may be reviewed prior to admission. Using the approved Review Criteria generally available to the Medical Staff and other Clinical Staff, the Committee or its designated individuals will consider specific information in carrying out the review.

On the basis of the "admission review," using Committee approved Review Criteria, admissions will be classified as "necessary" or as "questionable." If the admission is considered "necessary" an initial "extended stay review date" will be assigned. If the admission is "questionable," further review procedures will be carried out, in the order felt most appropriate by the Committee Chairman.

After such further review, if hospitalization is felt to be "necessary" an "extended stay review date" will be assigned by the Committee. However, if after further review, the final determination of the Committee is that hospitalization is not necessary, the Committee shall give prompt oral and written notification to appropriate individuals and agencies. Such notice will state clearly that further stay is not considered necessary and therefore is not payable by the program involved.

The Utilization Review Committee will apply the following criteria in making recommendations applicable to justification for hospital admissions:

Each criteria is noted numerically with regard to intensity and is assigned a maximum rating, which is an expression of the relative importance of that criterion in favor of hospitalization.

(NOTE: A dividing line which makes hospitalization necessary should be established, most preferably after a test period of these particular criteria). . . . Suggestion, dividing line of 10 until such time test period has been completed.

CRITERIA FOR ADMISSION REGIONAL MENTAL HEALTH CENTER—CSH

Numerical Rating — Category

I. Present Mental Status

0—Good mental health.

1—Mildly impaired mental status as in mild neurosis, character, and personality disorders, or mild mental changes due to aging; e.g., anxiety behavior, physical agitation, pressured speech, manneristic behavior.

2—Moderately impaired mental status as in moderately severe neurosis or character disorders, organic brain syndromes of moderate severity, moderate impairment in reality testing, such as in ambulatory schizophrenics or reactive depressions; e.g., crying spells, sleep disturbances, eating disturbances, neglect of personal appearance, extreme social withdrawal, flat affect, psychomotor retardation.

3—Markedly impaired mental status with poor to tenuous contact with reality [2] as in organic brain syndromes, schizophrenic reactions, and moderate depressions; e.g., delusions, grandiosity, paranoid thinking, hallucinations, auditory, visual, tactile, olefactory, etc.

4—Extreme impairment of mental status, complete loss of contact with reality, severe psychotic reactions, regressed or agitated schizophrenics, severe manic or

depressive states, and severe toxic or organic brain syndromes.

II. Self Care Ability

Financial competence, food intake, personal and room cleanliness, autonomy of physical health, sphincter control, responsibility for family and possessions.

0—Able to care for self adequately.

1—Requires assistance in two or more of above areas.

2—Requires extensive care in regards to such things as; not taking medication, wandering away from home, uncontrolled epilepsy, neglect of personal hygiene.

III. Responsible Parties Available
(Relatives and/or friends)

0—Patient is independent, or responsible parties are permanently available.

1—Inadequate or marginal care supplied on temporary or involunatry basis.

2—No responsible parties available to a patient unable to care for himself.

IV. Patient's Effect on Environment
(Family or community)

0—No adverse effect.

1—Slight nuisance or burden.

2—Severe nuisance and annoyance requiring much time and energy to combat effect.

3—Intolerable to family and/or community.

V. Danger Potential
(to self and/or others)

0—Harmless to self and others.

1—Has threatened harm to self and others, or might be advertently dangerous. Threats of aggression, aggressive ideation.

2—More menacing threats of danger to self and others with history of "acting out."

3—Homicidal, suicidal, or destructive to the point of requiring restraint to protect self and society, attempted suicide, suicidal ideation.

VI. Alcohol and Drug Abuse

0—No adverse affect.

1—Currently intoxicated.

2—Danger of withdrawal complications.

3—Mixing medications and alcohol.

4—Acute withdrawal state.

[3]

VII. Administrative

1—Failure of outpatient or extended care management.

2—Referral from mental health agency or professional.

3—Inaccessability of outpatient psychiatric care.

4—Eligible veteran with a vacancy in Veteran's Unit.

5—Legal mandate for involuntary applicant.

The scale is seen to provide a scoring range from 1 to a maximum of 25 points. It has been developed to provide a systematic basis by which to make a decision to hospitalize a mental patient. It combines clinical psychiatric evaluation with community and social factors. It can be easily recognized that there is no single category which determines the need for hospitalization. Instead, there appears to be an interdependence of categories. It should be noted that ratings have validity only at the time of the evaluation and can change radically in brief periods. Individuals with relatively low ratings may have changes occur in their situation which may reflect in a higher rating at re-evaluation and may at such time require hospitalization. It should be noted that "community factors" such as the patient's danger potential and the community's or family's ability to care for and tolerate the patient are important factors in deciding the need for hospitalization. A rating falling on the dividing line or relatively near, either above or below may be necessarily referred for consultation at the discretion of the Committee Chairman.

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[4]

UTILIZATION REVIEW COMMITTEE

6 May 1975

Conference Room, C&A Unit

The Utilization Review Committee of Central Georgia Regional Hospital met 6 May 1975 at 11:00 a.m. in the Children's Building Conference Room.

PRESENT: W. T. Smith, M.D., Chairman
L. Groves, Ph.D.
J. Perez, M.D.
D. Sans, M.D.

ABSENT: S. Aguilar, M.D.
C. Brookins, R.N.
W. Hertwig, ACSW
E. O. Melton, ACSW

The meeting was called to order at 11:00 a.m. by Dr. W. T. Smith, Chairman. The minutes of 1 April 1975 were approved as previously distributed.

NEW BUSINESS:

Eleven charts were reviewed and were found to generally indicate appropriate utilization in all aspects except one 13 year old boy (CSH# 205560) was ordered here by the Clayton County Court with no indications of an effort to get him transferred to the Atlanta Regional hospital, and another boy (CSH# 172897) has been here over two and one-half years with a delay in getting proper release through the Family and Childrens Services.

The next meeting is to be held in the Veterans Unit.

WTS/bbh

Supreme Court, U. S.
FILED
AUG 15 1977
MICHAEL RODAK, JR., CLERK

VOLUME II—Pages 352-717
APPENDIX

IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

APPEAL DOCKETED MAY 21, 1976
JURISDICTION NOTED MAY 31, 1977

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IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR LAWSON H. BOWLING, taken on the 4th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
DAVID GOREN, ESQ.
STEVE GRANBERG, ESQ.
Georgia Legal Services Programs
Macon Regional Office
653 Second Street
Macon, Georgia 31201

For the Defendants: DOROTHY Y. KIRKLEY, ESQ.
Assistant Attorney General
Department of Law
132 Judicial Building
Atlanta, Georgia 30334

[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The signature of the witness was specifically waived by his attorney of record, Ms. Dorothy Y. Kirkley, Esq.)

[3]

LAWSON H. BOWLING, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your name for the record, please?

A Lawson H. Bowling, M.D.

Q And where are you employed, Doctor Bowling?

A I am the superintendent of the Georgia Regional Hospital at Atlanta.

NOTE: (Defendant's Exhibit Number One was marked for purposes of identification.)

Q Would you identify Exhibit One? Just state what that is, please, Doctor? Just state what that is.

A This is a curriculum vitae on myself.

Q And how long have you been superintendent at Atlanta Regional, Doctor?

A Since May of 1968.

NOTE: (Defendant's Exhibit Number Two was marked for purposes of identification.)

[3]

Q Now if you would just identify briefly Exhibit Two and its component parts, then we'll go back into each of them in some more detail later in your testimony.

A All right. This is a looseleaf notebook which contains the following lists by patient number of the children admitted—of the persons admitted age seventeen and under to the Georgia Regional Hospital of Atlanta since January 1, 1969. It shows the diagnosis made on these persons and whether they were voluntary or involuntary patients. It shows the date the person was separated from

the hospital, whether they were on convalescent leave, and it shows the discharge date and to whom they were released. It also contains a list by initials of children who were denied voluntary admissions, including referral to the Comprehensive Community Mental Health Centers in the hospital's service area. It contains written policy and procedure of the childrens—child and adolescent program for periodic review of patient cases. It contains the written admission policies of the child and adolescent program, and it contains the hospital's policies and procedures for periodic review of patients by the hospital's quality review committee, which is a committee of the medical staff, and this is commonly called a utilization review in which the committee undertakes to see if the utilization of the bed is proper, that is if the person occupying that bed should be occupying it.

Q Okay. Let's go back for a minute to the first thing, the itemized list of patients.

[4]

A All right.

Q We were discussing that off the record a minute ago, and we determined, did we not, these were done manually and they're not in any particular order according to date or patient number?

A That's correct.

Q Who prepared that summary, Doctor?

A That—that summary was prepared by the staff of the Patient Affairs and Records section of the Atlanta Regional Hospital.

Q Could you describe, please, what your role and duties are as the superintendent of the hospital?

A Yes, as superintendent of the hospital, I am directly responsible for the entire operation of the hospital, for its administration and for the treatment programs and for establishing policies and procedures for the proper operation of the hospital.

Q Okay. What counties does Georgia Regional Hospital at Atlanta serve?

A It serves Cobb County, Douglas, Fulton, Clayton, and the central and south services areas of Dekalb County.

Q Are there also community mental health programs within this area?

A In that area there are nine established and operating comprehensive community mental health centers.

Q Do they have satellite offices, also?

A Some of them do.

Q And what is your relationship with the community mental health centers?

A We have written agreements with each of these centers as to [5] the function of the center and the function of the hospital. The basic philosophy of those agreements is that—which is the basic philosophy of the hospital, is that persons will be treated in the comprehensive community mental health centers in every possible instance, rather than being hospitalized. The hospital's philosophy on hospitalization—this applies to all patients, including the children and adolescent patients, is that hospitalization is to be carried out only when the person is, by reason of mental illness, unable to control his behavior, or constitutes—by that—for that reason, a threat to his and other person's physical safety, when all alternatives to hospitalization have been exhausted, and discharge

planning is begun upon admission. I'd like to add a statement of fact to that, and that is that the hospital has been critized in the public media for not admitting patients. We've had statements come out in the press that the patients who are taken to the Atlanta Regional Hospital often beat the person back home that took them. The hospital's philosophy, then, is not to admit unless it is required for stabilization of out of control behavior and dangerous behavior. I'm talking about admitting—well, that is essentially the basic philosophy. We handle voluntary or involuntary applicants in a similar manner, and then relating to the comprehensive mental health centers —well, the basic policy of the hospital is to either admit to a bed or find a suitable alternate, and we seek out a suitable alternate to hospitalization in every possible instance, and the comprehensive community mental health centers that I mentioned, are [6] principle places that we make referrals to—if a person is not requiring hospitalization.

Q What are you—just in your own words, what are your policies with regards to admissions, and—with specific reference to the admission of children and adolescents?

A That they're admitted only when their behavior is unstable and out of control and constituting a danger to themselves or others.

Q What process would they go through to get admitted?

A When any contact is made with the hospital to admit a child, and this is true, also, with most adolescents, they are referred to their comprehensive community mental health center initially. The purpose of that is to

try all non-hospital alternatives first. The primary source of such patients is the—are the county departments of family and children services, and we have established relationships with them in such a way that when they have a potential—when they have a disturbed child before them, they—the Departments of Family and Children Services contact the comprehensive community mental health centers first, before calling us. We have that understanding with them. The purpose of that is to try to ensure inappropriate hospitalization does not occur.

Q Are there ever situations where a child would not go first to the community mental health clinic?

A Yes. Yes. I would like to add first before I answer that, that not all comprehensive community mental health center referrals are admitted, because the hospital has a screening procedure, even after they are referred to us from the mental [7] health centers, and the estimate as to how many of those are turned back is approximatel twenty-five percent.

Q Excuse me, that's even from the community mental health clinics?

A Even from the community mental health centers. We do have direct calls, and when that call comes to the hospital—I do have a document here that gives a rundown or those kinds of contacts as from January the 22nd, '75 up until the present time. It just covers that one-time period.

NOTE: (Defendant's Exhibit Three was marked for purposes of identification.)

A Then the hospital's childrens programs screening procedure is carried out, of which there is a copy of that written procedure in this looseleaf notebook under the tab

that's called admission policies and procedures. That procedure is carried out—the purpose of that is to make doubly sure that inappropriate hospitalization does not occur.

Q Who would be involved in that screening process at the hospital?

A The staff of the childrens unit. Then the kinds of persons that are involved in that are called screening coordinators, who are appointed by the program director of the child—of the children's service, and it includes these kinds of personnel, social workers, psychologists, an assistant director of education and a psychiatrist.

Q And this procedure is done after a referral is made but before the hospital—the child is admitted to the hospital?

A That's done before the child is ever admitted to the hospital.

Q You stated a minute ago what your philosophy was and what some of the criteria were for admitting people to the hospital, [8] that is if they were dangerous to themselves or others. Do you use that standard for children?

A Yes, we do. Dangerous to themselves or others, or behavior that is out of control.

Q Do you have any policies with regard to the joint treatment of a family while a child is in the hospital?

A It's standard procedure in the children's program to immediately involve the available—the parents in the treatment process.

Q Are you aware in any percentage of cases, of reluctance of parents to become involved in the treatment program?

A I don't know a percentage. There are a certain number, that it is difficult for us to get them and keep them involved.

Q Would you say that that would be—in ballpark, say a quarter of the time, ten percent of the time . . .

A No, I'd just guess that it would be ten percent. Twenty-five percent or less. The majority of the parents cooperate on that.

Q And that treatment program would be carried out for the family by the community mental health centers?

A Not necessarily. It's—I would say primarily, on the hospitalized children, it's done by our own staff, but it may be done by the community mental health centers.

Q Once a child is in the hospital, are there any procedures for reviewing his case?

A Yes, and these are set forth in this looseleaf notebook in the form of copies of those standing official hospital and children's program policies and procedures. One is entitled "Rounds", which is a regular meeting of the staff which takes [9] place once each week, in which they take a reading on the situation, the progress, and what is known as the "Staffing procedure", which involves—which involves a number of things. It involves an initial assessment of the problem, the formulation of the treatment plan, and—that is carried out—that is followed up by the regular rounds at which that is reviewed.

Q How often does one of these reviews occur, is there a stated time?

A There's a review of each case once a week.

Q By the—this policy on staffing procedures?

A Staffing procedure is done on the initial admission primarily to formulate a treatment plan for the patient, and there's a third part of that policy which is called "Termination conference", which takes place about the time the staff is of the opinion that the person—the child should be discharged.

Q Do you know how many in-patients you currently have on the children's unit?

A Yes, there are fourteen.

Q Does that include adolescents?

A No, it does not include adolescents.

Q Do you have a separate adolescent unit?

A We do not. The adolescent patients are admitted to the adult units, which are based on a geographic service area. They—there is an in-hospital day treatment program for adolescents.

Q How many adolescents are there currently in the hospital?

A I don't have that number. Yes, I'm sorry, I do have it. [10] The current in-patients, adolescents, twenty-two, and I gave the wrong number earlier for children. I said fourteen, it's seventeen, so that there are a total of thirty-nine adolescents and children combined.

Q What is the day treatment that you spoke of for adolescents?

A That is a treatment of activities, group therapy, which takes place during the hours of approximately eight A.M. until four-thirty P.M.

Q Is part of that a school program for the adolescents?

A Part of that is school, yes it is.

Q You spoke about geographic units. You mean like each county in your area is represented in your hospital by a ward?

A Yes, it is. There are one or more buildings in the hospital whose staff in that building are designated for patients from the—from these several counties that we mentioned earlier.

Q Is there a separate unit for each county that you mentioned?

A Some counties have one unit, there is one—and others have two. That has to do with the numbers of the patients that are admitted from the different areas because there are more people in some counties than others.

Q Okay. And the adolescents would be disbursed among those different units?

A They are, as far as their—as to where their treatments plans are formulated, they are formulated by the staffs of those geographic units, and the patients—and the adolescent patients live in those units, that geographic area.

Q But during the day they're all brought together?

A They are all brought together during the day in that day program.

[11]

Q Do you have any idea what the current average length of stay is for the children and the adolescents?

A I'm sorry, I don't.

Q Okay. You also spoke about a utilization review plan, and that's different, is it not, from the staffings and the rounds conducted . . .

A Yes, it is. That is outlined in the looseleaf notebook. That is a overall hospital policy and procedure which is part of the proceedings of the quality review committee of the medical staff, which—which committee is appointed by the president of the medical staff, who is appointed by me.

Q And how often would this utilization review occur?

A It occurs—they meet monthly to review utilization of beds in the entire hospital, including children and adolescents.

Q Would they review each case every month?

A No, they do not. They review a representative sample of cases. They would not review every case in the hospital every month.

NOTE: (Defendant's Exhibit Number Four was marked for purposes of identification.)

Q Would you identify that Exhibit, please?

A These are the admission documents and admission instruments on all patients who are currently resident patients at the Atlanta Regional Hospital, and it includes data regarding their social history. That's what it is.

Q And that's for each child who is presently a patient . . .

A That's for each child and adolescent who is presently a patient in the hospital.

[12]

Q Does this include social summaries?

A It's supposed to include the social data that we have. We do not collect a specific document that is called

social history. That—we have a data base that's collected on every patient and that includes social information, plus additional notes that may be made by social workers who are working on a particular case, and in instances where that was the case, that was attached to these individual admission instruments.

Q Would this include information gathered by the community mental health program if someone had been through a community program?

A It would include—yes, it would, although it would not be in the form of a document submitted from the center. It would include information that they may have obtained prior to the person's admission.

Q You were talking a bit ago about a screening committee even after a referral had been made by a mental health clinic, is that right?

A Yes, the screening procedure that's outlined in this written policy and procedure in this booklet is carried out, even on those patients who are referred by the community mental health centers before a final decision is made to actually admit the person.

Q Well, when . . .

A I'm talking about pre-adolescent children. I'm not talking about adolescents. They're handled by—in the same manner that adults are in those adult units.

Q Okay. In this screening process, does the screening committee [13] have additional information from the community mental health clinics like prior treatments and psychological examinations and psychiatric interviews?

A They do have additional information, and some of which may—some of which may be in writing, and some of which may have been obtained by them directly over the phone.

Q So the information in Exhibit Three would not necessarily be all the information upon which an admission decision was made?

A Wouldn't necessarily be all of it, that's right.

Q In this screening process, is another psychiatric interview conducted by the admitting physician?

A The pre-adolescent children—the pre-adolescent childrens unit has a psychiatrist who participates in the admission procedure, and he—he interviews—he at least sees personally—I'm sorry, that's not correct. He does not necessarily see the patient in person each time before he is admitted, but he makes the decision as to whether a person shall be admitted or not. That's done by the physician—by the psychiatrist. And the same is true of the adolescents in those adult units. All patients are admitted to the hospital on the decision of the hospital physician.

Q But you're saying it wouldn't necessarily be on the basis of a psychiatric interview by the admitting psychiatrist?

A Not necessarily.

Q Would admission be preceded by a psychiatric interview by a psychiatrist at the mental health clinic?

A I don't specifically have that knowledge.

Q Okay. Do you know of any problem with regard to parents who [14] are reluctant to take their children back home when your staff recommends discharge?

A I can't quantify that, but there are—there are problems in a certain number of cases.

Q Have you got an estimate as to what percentage of cases that might be?

A Twenty-five percent would be an estimate of that.

Q And how do you handle that reluctance, or that problem?

A The staff works intensively with those parents on a continuing basis, and where that's a problem, they address that as a problem, and if they're absolutely unable to place the parent—the child with the parents, or if it is determined by the psychiatrist that it would be undesirable for that child to be—in the interest of his mental health, that he be placed with those parents, then we seek an alternate foster home type placement in collaboration with the county Departments of Family and Childrens Services. I might say that on occasion our staff has—has sought out a foster home themselves, gotten the county Family and Childrens Services to certify that home as being proper to receive a child, and that was done in one instance just recently, a child in Fulton County, who had been in the hospital for two years. The staff sought out a foster home and that child was placed in that home just before Thanksgiving of this year.

Q But the resource you would use primarily for that would be the county Department of Family and Childrens Services?

A That's the primary resource we use to place those children.

Q And then sometimes—do they go into juvenile court to remove [15] custody from the parents?

A That happens in some instances, yes. By the way, I'm not sure about that child I mentioned, but a certain number of these children have no natural parental figures, so that we—we seek out surrogate parental figures, and family—home settings.

Q One of the contentions in this case, Doctor, is that there is a necessity for judicial proceedings in juvenile court prior to the admission of children to the hospital. As superintendent, do you believe that such proceedings are necessary?

A I happen to be of the opinion that they are not necessary, that there are many mechanisms to protect a child from, shall we say, just being thrown into a mental hospital. I've described a number of them, and how we do it at Atlanta Regional Hospital, how we undertake to do it. I—it's my opinion that where mental illness exists, that physicians and staffs of community mental health centers are trained and experienced in recognizing those conditions, and that the subjecting of a mentally ill child to a courtroom procedure, could be detrimental to his—could cause him anxieties and tensions, fears, that in my opinion would not be necessary.

Q That's all the questions I have.

EXAMINATION BY MR. GOREN:

Q Doctor Bowling, I'd like to ask you, initially, about the relationship with community health centers. Could you describe how they might get a referral and how that would lead someone to coming to your institution?

A Yes, I—you understand that I do not work directly with [16] them in those centers, but the—they might get a referral from an adolescent either presenting himself at that center with a problem, a parent presenting an adolescent with a problem, or a parent presenting a child with a problem. They might get a referral from a family physician, pediatrician, they might get a referral from the department—county Department of Family and Childrens Services. I guess those are the principle ways that people might approach them wanting a service.

Q Do you know what criteria the community mental health centers use in deciding whether or not to refer kids to your hospital?

A As far as I know, because of the relationships that Mr. Baeszler, who is the director of the hospital's program has developed with these centers, it is essentially persons whose behavior is out of control and constitutes a physical danger to themselves and others, that's the primary criteria.

Q Is that the same criteria that your hospital uses?

A Yes.

Q Do you know on what basis the community mental health clinics arrive at that decision?

A I do not. I don't know how they reach that decision, other than, I presume, overt behaviors on the part of the child or adolescent.

Q Do you know how they get that information about that overt behavior?

A No, I don't. I don't know whether they get it by hearsay from other persons, or whether they actually observe it.

Q But however they arrive at the conclusion that a child or an [17] adolescent is exhibiting dangerous behavior or behavior that's out of control, they then would refer the case to your hospital?

A (No audible response.)

Q And specifically how would they do that?

A They would call the hospital childrens unit and state the problem, whereupon we would have them enter the child into our screening procedure which I tried to describe earlier, and which is outlined in this booklet.

Q You don't know if that child was first examined by a psychiatrist at the community clinic before the case was referred to your hospital?

A I do not specifically know that. I do know that those centers have psychiatrists. I do not know whether they specifically have an examination by a psychiatrist in each instance. I just don't know that.

Q Do you know if they are psychiatrists who work in the center, or are they consultant psychiatrists?

A My—I should think that in most instances they are consulting psychiatrists on a part-time basis. I don't know specifically of any of those centers that have a full-time child psychiatrist.

Q You also mentioned that you believe that your hospital rejects about twenty-five percent of the referrals from the community clinics?

A Yes.

Q Do you know what percent the community clinics themselves reject?

A I do not.

Q Okay. In the screening review at your hospital after a case is referred there, do you know exactly what that screening review [18] consists of?

A Well, it consists of—of everything that's outlined in this type of procedure. I don't know how do give you a capsule summary of that because the . . .

Q Well, how long would the screening procedure take before it's finalized and before a decision is made?

A Those—the decision is made at the—at the screening appointment, which is referred to in that policy procedure, and prior to that time there are considerable amounts of data gathered about the child, which is outlined in there, and I would say that the screening appointment and the actual procedure would consume about two to three hours on the average.

Q Is it important to gather such data?

A To gather the data prior to that appointment? In my opinion it is.

Q Why is that?

A To—to obtain as much information as the staff can as to what has happened to that child in the past and what may have happened to him prior to him—as to the reason for referring him for hospitalization. The information, of course, is accepted from other persons. It's not a direct experience of the staff of the hospital.

Q How is this information verified by your screening procedure?

A It is accepted on the basis of any verbal information that's given, of the staff of the hospital knowing or accepting the statement of the person that they are talking to, that they are staff of the centers, and they—members of our staff spend a certain amount of time in these centers, so that [19] many times the persons know each other personally and know that they are on the staff of these treatment centers, and the written documents would usually bear the letterhead of the referring center.

Q Who would you believe would be the primary source of information when a child or adolescent is to be admitted to your facility?

A Who would be the primary source of information?

Q Yes.

A You mean as to who—as to who would be the person that would best be interviewed?

Q Right.

A I would say that probably the child's parents or parent surrogates, but not—wouldn't limit it to that. It should be—there should be additional information obtained from such persons as a family physician who may have made observations of the child in a professional manner.

Q In regard to the parents or the surrogate parents, you mentioned that with a certain percent of the cases, and I believe you used somewhere between ten percent and twenty-five percent, you noticed that parents were reluctant to participate in their responsibilities for their children, is that correct?

A That's what I said, yes.

Q Okay. Why do you think this might be?

A I think there can be a variety of reasons. It can be such things as the parents feel guilty about having a disturbed child. They may wish to have some professionals or other [20] persons to make this child different in his behaviors from what he is. They may feel guilt that they did not—that they did something wrong in rearing this child. Those would be the principle reasons that I think they might be reluctant. It's possible that they might not

want the child. But all of those things would have to be determined on each individual case, on an individual basis, and that is what the staff is trained to do in their professional practice.

Q Sure. You mentioned that one of the keystones is involving the family itself in treatment?

A That is axiomatic in the treatment of children, is to treat the parents and the child. It's considered to be a constellation of disturbance that exists, that where there is a mentally or emotionally disturbed child, that it relates to the parents.

Q And therefore the parents themselves require treatment?

A Yes, they do, they require—the parents and the child are all treated in the treatment plan for the child.

Q Because of these kinds of situations, is it possible that parents may misperceive or misinterpret or distort facts when they are asked information about their children?

A Yes, that's possible.

* * * * *

[22]

* * * * *

Q But one of the things you said, I believe, was that it's often difficult to get parents to volunteer some information. An example that might come to mind is, if the child—excuse me, if the parent had a record of child abuse, do you think that would be information that they would readily make available to the screening . . .

[23]

A I would say they'd be more likely not to readily make that available than they would but there would be

a certain number of them that might volunteer that information.

Q And for those who wouldn't, would it be helpful in making your decision to hospitalize if a court could discover that information and make it available?

A If that information were available to the staff, it would enrich their data base, in making their decision.

Q Okay. When you were describing the admission procedure, I don't know if I misunderstood you or not, but is a child, before he's admitted to your hospital, always examined by a psychiatrist at your hospital?

A He is always examined within twenty-four hours after admission. The psychiatrist may decide to admit based on the findings of the screening procedure, without necessarily directly examining that child. I would say that in most instances he actually does.

Q Would this be a . . .

A He definitely does it within twenty-four hours, which is the requirement of the Georgia law. The Atlanta Regional Hospital has a one-half-time child psychiatrist on the staff of this unit. The back-up to him is the psychiatric and other medical staff of the hospital.

Q Okay. You made a distinction before concerning—it seems like you make an important distinction between children and adolescents. At what age is the dividing line?

A The—what we call a pre-adolescent person is a person through the age of eleven, and an adolescent is a person age [24] twelve through sixteen. Those criteria were established by the Division of Mental Health of the Department of Human Resources.

Q Okay. How are pre-adolescents or children treated differently than adolescents?

A There is a separate building and staff for pre-adolescent children, and the adolescents are treated—I should say the—in both cases the treatment plans for these persons are developed—the treatment plan for the adolescents is developed in the geographic units. That is a major, essential difference in the way they're treated. In both instances—in the instance of both pre-adolescent and adolescent persons, there is a development of a specific written treatment plan for each individual, and in the—another difference is that in—although in the instance of both the pre-adolescents and adolescents efforts are made to work with the parents, that is intensely pursued with the pre-adolescent children. Those are the essential differences in the way these two groups are treated.

Q Is there a difference in admission procedures?

A There is a difference in the admission procedures.

Q What is that difference?

A The difference is that the adolescent patients are not—do not go through this elaborate screening procedure that the pre-adolescent patients go through.

Q Why would that be?

A The geographic units have—have their admission policies and procedures which are not—which do not include this [25] —this very elaborate screening procedure.

Q Why do you make the distinction between children and adolescents?

A Well, I suppose it's because that those units, being essentially adult units, they—there's never been a special admission procedure for the persons who are less than seventeen.

Q Okay. A child in the scheme at your hospital who reaches the age of twelve is considered an adolescent?

A Yes.

Q And a twelve-year-old would then be put on a geographic unit?

A That is the basic policy and practice. It is not followed in every instance because the staff on the preadolescent unit will sometimes retain a person a bit beyond that age limit in the interest of his treatment.

Q And on the geographic wards are adult patients? Say there might be situations where you would have a twelve-year-old on a unit with adult patients?

A Yes, that's correct.

Q What is it, in a child or adolescent which would make your hospital want to treat them so differently?

A That situation arose through a series of circumstances that goes back some years. The hospital never opened a separate unit for adolescents with a separate staff, and until 1973 the hospital did not receive and treat any adolescent patients. The—in 1973 the Division of Mental Health established a policy that all persons in the geographic area of the hospital would be treated, and we began to receive adolescent patients in the adult programs, and that's—that's how that situation, as it now exists, occurred.

[26]

NOTE: (Brief off the record.)

Q Doctor, we were discussing the difference in your hospital between how children and adolescents are treated, and you were describing that children are considered to be persons between—up until the age of eleven, and are considered adolescents from the age of twelve to sixteen.

A It's through eleven and from twelve to sixteen.

Q Okay. Is it your opinion, then, that adolescents are developed to the extent that they could function most properly on an adult ward?

A They—there is disagreement in psychiatry and in child psychiatry as to whether adolescents require a separate unit and a separate staff. There is no disagreement that each adolescent person requires a specific treatment plan, and that most professionals believe they should have a special treatment program, but that they do not have to live in a separate unit. Or they may or may not live in a separate unit, and they are—that is an issue that the experts will disagree on.

Q Okay. Did you say that you felt that a hearing that might be provided for a child, might have some detrimental effects on that child?

A I did say that.

Q Do you think those same effects would be present in an adolescent?

A Yes, I think they could be.

Q How about an adult?

A Let me modify my statement about adolescents to say that I [27] think it would be less so in an adolescent who had his personality more formed, and I would not equate the experience in the three groups. I'm giving you my opinion. My opinion would be that it could stimulate

—you might want to know in what way would I think it would be harmful. I think it would stimulate fantasies in a pre-adolescent child that he—that might would cause him to wonder what was going on or what might happen to him, and that—well, excuse me.

Q Wouldn't he also wonder what was happening, what was going on, when his parents take him to be admitted to the hospital and he finds himself—and he is accepted by the hospital and he finds himself in the hospital?

A Yes he would. Either procedure is a ritual or scenario which could stimulate fantasies that would produce—could produce anxiety or fear in the child.

Q Okay, but these wouldn't . . .

A Uncertainty.

Q These wouldn't necessarily be present in adolescents?

A I think they might be present—I think that they could be present, but that their impact on the person would more likely be less. The person could handle it better, so to speak. In a more realistic manner—handle it in a more realistic manner.

Q Okay. Do you know how many adolescents there are on the adult wards at Atlanta Regional?

A Yes, it would be the number that we have in the house at this time. Twenty-two.

[28]

Q I know it's hard to try to reach specific ages, but would a child or an adolescent at the age of twelve be able to handle a hearing without too much detrimental effect?

A I would not be able to set an arbitrary age on it, because there would be individual variations.

Q Okay. In other words, a twelve might—a particular twelve year old may be able to function fine, whereas one who would be older might have more problems?

A That's possible, because there's a tremendous variation among individual human beings.

Q Do you know if there are any twelve-year-olds on adult wards?

A Yeah. I don't specifically know that as of today, but there very well may be, and there certainly have been.

Q This policy for distinguishing between persons through the age of eleven and persons through the age of sixteen, is that a policy specifically of your hospital, or is that a state-wide policy?

A That is a policy of the Division of Mental Health of the Department of Human Resources. It's not a specific hospital policy.

Q Okay. Excuse me, you said it's not a specific hospital policy, but the entire . . .

A It is a policy of the Division of Mental Health of the Department of Human Resources. You asked if it was state-wide, that would make it state-wide.

Q It's your impression that all of the regional hospitals make this distinction?

A That's my understanding. I don't specifically know that to be [29] a fact, but that is my impression, yes.

Q Do you have any written policies from the division that spell out—making this distinction?

A I don't believe I have a written policy that spells that out.

Q But that policy was told to you?

A That policy was told to me by Doctor Charles Bush, who was the former Deputy Director of the Division of Mental Health.

Q And does the same policy . . .

A And it's never been rescinded. Excuse me.

Q Okay. Do the same distinctions between children and adolescents at the admission stage, come from policies that are also told to you to be state-wide?

A The—you mean in the procedures for admission?

Q Yes.

A Those procedures that I outlined to you are the procedures of the Atlanta Regional Hospital. I'm not aware of the specific procedures of the other hospitals.

Q Okay. Doctor, concerning the admissions of children, do you know the percentages—excuse me, let me ask first, is there a certain standard for diagnosis, a standard document that you refer to to make diagnosis?

A There is, and it's—it's the International Nomenclature of Disease, I believe is what it's called.

Q You do not use D.S.M.-2?

A Is that the—what is D.S.M.-2?

Q The Diagnostic and . . .

A Yes, yes, yes, we use that terminology that's listed n the Diagnostic and Statistical Manual of the American Psychiatric [30] Association, I believe, and that list is

contained within the International Nomenclature of Disease.

Q Okay, I see. Using those diagnostic categories, do you know which percentage—or what percentages of various categories that children who are voluntarily admitted to you hospital, fall under?

A I don't have that breakdown. I don't have that collated.

Q Do you have any idea as to—any approximation as to which category would be more prevalent than other categories?

A Yes, I would say that the--that the two—two most prevalent ones would be number one, schizophrenia, and number two would be behavior disorders of childhood and adolescence.

Q What would they include?

A Well, the Nomenclature has seven separate classes that come under that heading. Do you want me to name those off?

Q Only a few who would think that—some particular ones of those would be the most common in that category.

A I would say that probably the hyperkinetic reaction would be the most prevalent.

Q Okay. Upon admission, are children and/or adolescents informed of their rights as patients?

A They are.

Q How is that done?

A That is done by the admitting staff in the admitting process on a verbal basis to the child.

Q Are there any written policies, procedures describing how to effect this information?

[31]

A I don't believe we specifically have that. There are written policies and procedures in the hospital that—that do require staff to impart such information to all patients who are admitted.

Q And that would include children?

A That would include children and adolescents.

Q Are they given any written notice of these rights?

A The—each patient that's admitted to the hospital is given a copy of a booklet that is put out by the Division of Mental Health. It's called Your Rights Under Georgia's—in Georgia's Mental Health Facilities.

Q Is that written especially for children?

A No, it's not. It is written for—it is written for any patient admitted, but it is not written especially for children.

Q Okay. In your experience have you ever observed, say, an adolescent objecting to his confinement in the hospital?

A I can't cite you a specific instance, but we—he has every right to do so and there are written hospital policies and procedures as to what is to be done when a person does raise such objections. For instance, there is a right to apply for discharge, and there are written policies and procedures in all units in the hospital's manuals that are on all units, that spell out that procedure.

Q A child can do that also?

A I can't specifically tell you how that's handled. A child would have that right, but I can't tell you that we systematically practice that as a procedure.

[32]

Q As far as adolescents are concerned, do you know the procedures that are involved and how they would effectuate their rights?

A Yes, they can—they can say to any staff member at any time that they do not wish to be—that they wish to leave the hospital, and whereupon the standing policy and procedure is to be carried out. Now the essence of that is, that the person or his parent or guardian puts that in writing, and we actually have forms that they can use for that purpose, which the procedure calls for the staff making available to them, and then that document is dealt with so that the case physician reaches a decision as to whether, within a specified period of time, as to whether or not that discharge shall be granted, or whether the hospital shall take steps to prevent it.

Q Can that request for discharge only be done by the parent or guardian in the case of a voluntary admission of a juvenile?

A I believe that—that that's correct, because that is the—the way that we understand that the law is presently structured. Code Section 88-5 is what I'm talking about.

Q Okay. And this—and it's possible that this could be the same parent or guardian who you said might have a conflict of interest with the . . .

A That would be possible.

* * * * *

[36]

* * * * *

Q What would the effect be if there were, say, an advocate for the child or adolescent at these rounds or at the reviews that you [37] have, an advocate who would not be there to disrupt the proceedings, but just to speak on behalf of the patient?

A I would say no—no objections to that.

Q Okay.

A And it could be helpful.

Q In the same sense, do you think it might be helpful to have an opinion of someone who is outside of the system, someone who in the same sense could give a different perspective like an advocate . . .

A Well, that wouldn't hurt anything. That wouldn't hurt anything, and it could be helpful.

NOTE: (Brief off the record.)

Q Doctor, how many physicians do you have in your facility?

A We have eleven full-time and the half-time child psychiatrist.

Q Are these physicians board certified in psychiatry?

A There are three of us who are board certified, three out of the eleven who are certified in psychiatry.

Q And are all the others licensed to practice medicine?

A Yes, they are.

Q Are there any licensed only to practice in a state institution?

A There are two physicians who are licensed to practice only in the institution.

Q Are there any foreign born or trained physicians?

A Yes, there are.

Q How many are they?

A Four.

Q Do any of these physicians have difficulty with the English language?

[38]

A These particular ones do not with the exception of one, who has, I would say, minimal difficulty, in one physician whose primary language is Russian.

* * * * *

EXHIBIT 2

Screening Procedure

CHILD AND YOUTH SERVICES

January 20, 1975 Policy # 2, Part I

I. Referral taken by Screening Coordinator.

If coordinator is not available, the referral will be channeled to any one of the following team members.

A. Social Worker
B. Psychologist
C. Assistant director of Education
D. Psychiatrist

II. Phone Contact Sheet

During the referral (Initial contact) the team member taking referral will complete the Phone Contact Sheet.

Each team member will have xeroxed supply of Contact Sheets (sheet attached page # 1a).

Determine as soon as possible if the referral is appropriate (i.e., has been referred to GRHA by private psychiatrist or psychologist or has been through a mental health center). If referral is appropriate complete all questions on Phone Contact Sheet. If it is not a correct referral, supply person with name and phone number (see attached page 1B) of the mental health center in his area.

File original Phone Contact Sheet of those referred elsewhere in manila file folder located in secretary's file cabinet (drawer labeled "Screening"). The folder is labeled "Phone Contacts Referred".

Contact sheets of those not referred will be filed under "Phone Contacts—Appointment Scheduled." Location for this file will be the same file cabinet labeled "Screening".

III. Scheduling the screening appointment.

If the referral is appropriate, schedule a screening appointment at GRHA no sooner than four working days after date the contact call is received. The minimum four day period is to allow the screening team to gather all the information needed to assist in the disposition.

Record appointment date on blackboard and in the screening appointment book located at Ward Clerk's desk.

Xerox copies of contact sheet. Place one in each team member's communication mail box, place one in the folder established for child.

Folders to be established for each child scheduled for screening evaluation. The folders will be located in the same file cabinet as Phone Contact Sheets (drawer labeled "Screening").

After the screening appointment, the original phone contact sheet in folder labeled "Phone Contacts—Appointment Scheduled" will be (1) put in chart if child admitted, or (2) stapled to folder on child if child is referred elsewhere for treatment.

The team member taking the call is responsible for getting (1) contact sheet xeroxed, (2) getting copies of contact sheet to all other team members, (3) starting folder on child, (4) recording appointment on blackboard, (5) recording appointment in screening appointment book, and (6) putting original phone contact sheet in correct folder.

The screening team members are:

(1) Coordinator
(2) Social Worker
(3) Psychologist (alternate: Psychology Technician)
(4) Psychiatrist
(5) Assistant Director of Education (alternate: Teachers)

Each team member will be responsible for gathering certain information pertaining to their particular area.

IV. Assistant Director of Education: Information; responsibilities.

(1) Contact present or last school attended.
(2) Visit the school and observe the child in the classroom, if possible.
(3) If a visit to the school is not possible, contact the teacher by phone. Counselors or school social workers are alternates.
(4) If the school is closed (summer, holiday) contact area office, caseworker or parent for information.

Complete 1 page or less hand written xeroxed report of findings. Distribute copies to team members no later than 1 hour prior to screening appointment.

Put copy in child's folder.

Put copies of any reports received from schools, etc. in folder.

V. Psychologist: Responsibilities

(1) Contact the referring agency or doctor to determine testing information (extent of) available.
(2) Psychological tests will be administered if need is determined by the psychologist.

Criteria for testing:

(a) No testing available within last six months.
(b) Question as to validity or prior scores.
(c) Determine if child in in TMR, EMR range.
(d) Psychometric services not available at the community level.
(e) Question of LD problem.

(3) Possible need for condensed battery of tests. Though not as thorough as administering complete tests, the condensed version would give staff a general idea of where the child is functioning.
(4) Testing, etc. can be administered by the Psychology Technician.

If the Psychologist determines need for testing (by above criteria) and it is not available on the community level, the testing is to be completed during the four day period; (a) on one of the four days prior to the screening appointment, or (b) on the same day as the screening appointment.

Complete a one page or less handwritten report of findings. Xerox, distribute copies to team members prior to screening appointment.

Put copy in folder.

VI. Screening Coordinator.

(1) Receives phone contact.
(2) Schedules appointments.
(3) Periodically checks to see if appointments are:
  (a) on board
  (b) in notebook for appointments
  (c) folder established on child
  (d) phone contact sheets in correct location. Team members have xeroxed copies.
  (e) responsible for getting information from referring agency.
  (f) involve community mental health center in screening appointment; determine if representative from mental health center will be at screening appointment; coordinate involvement of community mental health centers and their contractual agreements with other agencies and staff member responsible for implementation of contractual agreements at GRHA.

VII. Social Worker/Social Work Technician

After taking phone contact or receiving notification of contact and appointment scheduled, the following items are to be completed:

(1) Make or coordinate home visit if possible.
(2) Gather as much information as possible on family. Get reports from DFCS, Juvenile Court, etc. if involved.
(3) See that agency representatives who attend screening are treated professionally.
(4) One page or less hand written report on family, social history. Distribute to team members no later than one hour prior to screening appointment.
(5) Xerox copies of information to child's folder.

VIII. Screening appointment.

(1) Thirty minutes before screening appointment the team members assemble to discuss findings Primary Therapist tentatively assigned at this point. If Primary Therapist is not team member, is notified to attend screening appointment.
(2) Client arrives and secretary assists parent or guardian in completing face sheet.
(3) Team members meet briefly with community mental health representative, caseworker, and other involved service workers.
(4) Client and parent or guardian (unless is above mentioned caseworker, etc) meet with team members and other agency representatives.
(5) Interview child with parent in room.
(6) Child, parent/guardian asked to remain in lobby while team members make disposition.
(7) Parent/guardian informed of disposition. If referred elsewhere, the name and phone number of referral agency is given to the parent. Dis-

position is discussed with mental health representative.

If admitted:

(1) Primary Therapist above assigned completes data base with parent's assistance.
(2) Secretary has parent/guardian complete all consent forms, other necessary paperwork.
(3) Parent meets with Social Work Technician to complete research forms.
(4) Staffing coordinator assigns staffing date.

If there are no beds available the child is placed on a holding list. Admission will be upon availability of a bed.

Final decision for admission will be with the consulting psychiatrist.

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

DEPOSITION OF

GLADELLE WHITAKER

Taken on behalf of the Defendants.

APPEARANCES:

For the Plaintiffs: MS. NANCY LINDBLOOM
Attorney at Law
Macon, Georgia

For the Plaintiffs: MR. GERALD R. TARUTIS
Attorney at Law
Macon, Georgia

For the Defendants: MR. DOUGLAS LACKEY
Attorney at Law
Atlanta, Georgia

[2]

This testimony came on to be heard in the District Office of the Department of Human Resources, located in Gainesville, Georgia, at approximately 3:00 p.m., December 4th, 1975.

MR. LACKEY: This is the deposition of MRS. GLADELLE WHITAKER, taken for the purpose of evidence in the matter of J.L. and J.R. versus Jim Parham, et al. The parties hereto have agreed to reserve all objections, except as to form.

(Signature of the witness is waived.)

GLADELLE WHITAKER,

being first duly sworn, was examined and deposed as follows:

EXAMINATION BY MR. LACKEY:

Q Would you state your name for the record?

A Gladelle Whitaker.

Q What is your address?

A 223 Lucille Lane, Toccoa, Georgia.

Q What is your occupation?

A Director for Stephens County Department of Family and Childrens Services.

MR. LACKEY: Council for the Plaintiffs and counsel for the Defendants stipulated that Mrs. Whitaker is the custodian of the file—(To the reporter.) Off the record.

(The parties went off the record for a brief [3] period of time.)

MR. LACKEY: Counsel for the Plaintiffs and counsel for the Defendants have stipulated that Mrs. Whitaker is the custodian of the record of Jimmy, a child, a minor child, who will be identified throughout this Hearing either as J.R. or Jimmy or James. We further stipulated that certain documents, which have been excerpted from that record, are true and correct copies of the documents contained in that record and that parties will stipulate that these documents are being included in the Court's records with this deposition, subject to the objections, which the Court has directed the parties to reserve. The documents themselves are broken down in

this fashion: There is one white folder of materials, which refer to the psychological examination given to the child; there is one white folder, which contains documents relating to placement attempts, attempts to place the child; one white folder, which relates to reports of the child's behavior in various foster homes and other situations; there is one group of documents, not in a white folder, which are the reports of the case worker assigned to Jimmy, beginning in December of 1974, and continuing through the present date; there is one set of documents, which constitute the Court order, the Petition, and supporting documents, which resulted in Jimmy's custody being given to the Stephens County Department of Family and Childrens Service. I don't know [4] how to identify the materials in the documents any more clearly than that, unless you have something you want to add.

MR. TARUTIS: You can say that counsel further agrees that these documents will not be attached to the deposition itself, but will be submitted under separate cover and will be numbered consecutively by counsel, jointly.

MR. LACKEY: We have stipulated that any objections to these documents will only be to their relevancy and not to their—and not to the form of admission. In other words the documents have been properly tendered, subject to your objections as relevancy.

MR. TARUTIS: Off the record.

(The parties went off the record for a brief period of time.)

MR. TARUTIS: Councel further agrees that Mrs. Whitaker is the custodian of the documents, that the documents have been properly identified and placed into

evidence—have been properly identified and tendered for placement into evidence.

MR. LACKEY: Subject to your objections?

MR. TARUTIS: Right. Counsel has further agreed that Mrs. Whitaker is the custodian of these records and that these records have been properly identified and tendered into evidence, subject to the objections of Plaintiffs in this matter.

[5]

Q Mrs. Whitaker, you stated your position was County Director of the Department of Family and Childrens Services of Stephens County; how long have you been in this position?

A Seven and a half years.

Q Where were you employed before you became County Director?

A As a case worker with the Stephens County Family and Childrens Services.

Q How long were you in that position?

A Nine and a half years.

Q As County Director, what are your responsibilities particularly with respect to adoptions and foster care in the county?

A The Department of Family and Children Services has a responsibility for adoption, foster home placement, working with protective services for children, which includes abandoned children, children neglected or referred to us.

Q Without referring specifically to this case, can you tell us generally what the procedure is in Stephens County

for the placement for adoption or for foster care for children in your county?

A Children that are in custody of the department or who are voluntarily released to the department, are the ones we actively seek foster homes for or if we have permanent [6] custody—you would, you know, consider for adoption, if they are an adoptable child—we try to use for foster care a placement of an approved foster home within our own county. If it's an adoption, with permanent custody, we submit material to the District Office, which engages in finding the adopted home. We don't seek adoptive homes for specific children. Then getting back to the foster care in our own county, foster parents have the right to state what type of children, age range, etc., they can provide or care for in their own home. In the event that we have a home that is full or does not meet the needs of a specific child that needs placement, we come to our District Office stating that we have this child that needs foster care and that we do not have a home for him in our county, and would she explore the district foster homes. She keeps the central file here. A lot of information is not given to her, such as specifics in homes. They just make a referral that this home has a vacancy within this age range. We contact a worker in the other county giving them some background information, some information on the child, to see if maybe their foster parents where the vacancy occurs could take care of this child. We either get a yes or no answer. If this doesn't materialize, then we let her know this, that we need to try to explore some other source over the state, then she handles it from there.

[7]

Q How do you go about securing persons to operate foster homes in Stephens County?

A This is an open decision—always we are open for people to file an application for foster care. We may have speaking engagements there at the Civic Club, programs on the radio or spot announcements, advertisements in the newspapers. We have been known, say, to run a campaign, but we're always open for people who may want to apply to become foster parents.

Q You said that there were speaking engagements and this type of thing, do you personally do that sort of thing?

A Yes. We involve either myself and maybe, you know, some of the caseworkers in the services department also.

Q Do you know how many foster children you have in the county now for instance?

A No, that's handled by the specific caseworker assigned to that responsibility.

Q I believe you stated that you went to the district and then went to the state. Do you have any connection as to what occurs at the state level?

A Not really, it's—you know, we make the request and the Social Services Director may tell us to get the material together and mail it directly to a person in the state. We are responsible for getting the summaries together and information on the child, that is our responsibility.

[8]

Q Okay. Let's talk specifically about the matter at hand, that being Jimmy. Can you tell us when you first became acquainted with Jimmy?

A Jimmy was brought to my department by a relative—

Q Before you do that—are you going to refer to those notes? If you want to look at them, feel free.

MR. TARUTIS: Off the record.

(The parties went off the record for a brief period of time.)

Q Do you recall when you first became acquainted with Jimmy's case?

A Yes. Jimmy was brought to our department by one of his relatives and a close neighbor of the family when he was three months old. Upon observations from, you know, lay people, because there was more than me involved, he seemed to be malnourished and not fully developed for three months as a child should be. This seemed to be an emergency as the child seemed listless, his head was larger than his body, his stomach protruded, his hands and his legs were just—no flesh, just very small. So, we carried the child to the Juvenile Court Judge, who made an observation and gave us an emergency order at the time to place him in foster care and get medical examinations. The parents were notified and he set a date for a Hearing, but the child was placed in an emergency situation at that particular time and he [9] was carried to a pediatrician, who gave a written report to the Court, the Judge, for the specific Hearing when the parents were involved. The Judge gave us the order for temporary custody; at the time he was about three and a half months old. He was placed in a foster home in Stephens County. The home was an approved home for us for infants, it was a widow lady. James was hard to discipline, he was a head-banger and he didn't seem to be fully developed, as far as developmental charts. And, this lady, as I said, was only approved for infants, so when he reached two years

old we thought he might have more stimulation in another home and develop. So we moved him into another home about the time he was two years old or just past two years old. He received good medical care during the time and it seemed as far as his physical development, to be fine. He did have the problem of head-banging, destructiveness, as far as his crib, and I believe he tore up a playpen by shaking. It was discovered that he had a hernia and after his placement in the second foster home he did have an operation in a local—in Stephens County Hospital for the hernia operation. This lady didn't feel that he was up to a two year old range and she felt that she couldn't cope with him and his problems of apparent temper tantrums and frustrations. So, it became necessary to remove him in an emergency to another lady there in that county, until we [10] could make some plans for him. So within that same year we had three placements to foster homes, in the hospital, before he went into a home in Fannin County.

Q What year was this, do you recall?

A This is where most of his behavior problems became apparent, he was referred to Crippled Children's—this was in 1964 and '65.

Q Where did he go next?

A Then he was referred to Aidmore Hospital for an evaluation, phychological, EEG, in an effort to determine what was causing the behavior problems, if it was physical and neurogical. He stayed there about two weeks and then I moved him from there to a home in Barrow County. During the time that I did move him—when I went to Aidmore to pick him up, I was unable to relate to the child. One of the attendants had to put him in the car. He

spit and threw things, and I had carried toys and stuffed animals, of course, to entertain him. He even threw those at me in the car. He seemed very frightened and he held on to the window handle until he relaxed and went to sleep. Then when we got to the foster home, he did the same thing. You know, outside he picked up a rock and, of course, being uncontrolled as far as aiming it, he hit the car with the rock, he spit at me. And, it was finally decided that the foster mother might be able to get him more accustomed to being at their [11] house if I left. So, we left him with these people.

Q What were these people's names?

A Timms. This was in November of 1965, he was placed with them. They worked real hard with him. We have records to indicate that they tried real hard to work with him and seemed to show some degrees of improvement, except at times when his attention span and low tolerance level would be evident. Then they had to ask for him to be removed due to circumstances. He never did quite relate to this particular family, he didn't stay there quite two years. Then in July, we found a home and went to the Satterfields, and this is in White County.

Q What year was this, please?

A In 7/18/67.

Q In July of '67, he went to the Satterfields?

A Right. And, this is where he had his longest stay.

Q How long was he there?

A He was there until 6/24 of 1970.

Q What responsibilities do your foster parents have with respect to the child's physical and mental well-being?

A Well, just as any parent would be to their own natural child. They are supposed to have proper physical examination, dental examinations. If there is a problem emotionally, referral to the proper source for evaluation and [12] treatment, if necessary. Our agency requires in the smaller children, with infants, monthly examinations and as they get older, you know, six months examinations or yearly examinations, physically.

Q I am handing you this file, which I have previously identified as the file containing the psychological information on the child. Do you recall when the child was first referred for psychological—let me rephrase that, when the child was first sent for a psychological evaluation?

A This file indicates that the earliest psychological was done in 1965.

Q Can you recall what—between 1965 and 1970—what psychological treatment or evaluation that the child was given?

A This would be under Crippled Children Services and this was the work with the nurse in Fannin County, with the referral to Aidmore pediatric psychological examination, and this is the reports.

Q So the trip to Aidmore was the first psychological evaluation?

A That we actually can recall.

Q Now, would you continue and I'm only concerned with the period, say, between 1965 and 1970. What other psychological evaluations did he have?

A Now, this is Doctor Clark at Aidmore in October of [13] '65, and the EEG was at Emory University Clinic in

October of '65. This record is a little bit fuller, because it gives some of the nurses' reports.

Q Is this still from Aidmore?

A Yes. It's Crippled Childrens Report, which would include Aidmore and it's more than this first one here, more detail.

Q If you're going to refer to the documents, why don't you—in the future, you don't have to do it with that one, but just identify them by date, if you could, and the letterhead, if there is one?

A I think the transmission of the material—December 12, '66, this is a psychological evaluation.

Q Who was that done by?

A This doesn't have any name, but when we submit a social summary for adoption we leave off names and this looks like a Doctor Young.

Q Who is Doctor Young?

A Florene Young at the Psychological Clinic at the University of Georgia in Athens. She felt he was a little bit—I can seem to remember—that she felt he was a little bit farther advanced and she wanted to test him again. So, she did so on April the 21st, of '67.

Q Another psychological evaluation?

A By Doctor Young. And, another one on May 1, '68.

[14]

Q By the same person?

A Yes, by Doctor Young. Then in '68, this is when he started exhibiting problems in the Satterfield home, because this changes—the psychologist and the referral—we have a psychiatric evaluation from Doctor Griffin.

Q Who is Doctor Griffin?

A He is a psychiatrist in Gainesville.

Q And, the child was referred to him when?

A October of '68. He was in the Satterfield home at that time.

Q He was referred to Doctor Griffin?

A Right. He also was seen by Doctor Goldstein on the same day.

Q Who is Doctor Goldstein?

A He's a clinical psychologist.

Q What resulted from these evaluations, anything?

A This indicated that he might need treatment and we set up ten treatments by psychiatrists.

Q Explain how that occurred, if you would, you say you set up ten treatments by psychiatrists?

A Well, the funding process and the money available for those, we have to get it approved and there is a special form for a request for psychiatric services that needs to be prepared.

Q Is that document you are referring to the referral [15] document?

A Yes, referral for psychiatric services. And, this was referred to the district office at that time, who gave the approval. That was the current policy in effect at that time, this was still in '69.

Q What happened after that?

A Then the Mental Health Clinic had something to do with it, this is a letter by Jean Meeks, who reviewed

Doctor Griffin's and Doctor Goldstein's evaluation, because he was having some problems.

Q Was this leading up to the approval for the ten treatments?

A No, that's after that.

Q Did the child receive the treatments?

A Yes.

Q Is that reflected in those files?

A I'm sure. Hall County Mental Health Clinic was to provide those. That's the letter indicating where they were set up. Those ten treatments were given through the Hall County Service—Mental Health. Then there was a mental health clinic that was set up as a satellite in Toccoa and we started taking him to the Toccoa Mental Health Clinic.

Q Who was in charge of that health clinic?

A This was a Mr. McFarland.

[16]

Q How often was he treated there, do you know?

A It seems that he started in May of 1969, and continued until he was placed in Central State Hospital, so it would be a whole year.

Q As I understand, he received treatment in Gainesville—

A Prior to May of '69, right.

Q —and then received treatment in this—

A On an outpatient basis.

Q —period at the mental health clinic?

A Right. This next document that follows in this file is the running narrative by Mr. McFarland, ACSW. And, it also has notes—but he was also seen by Doctor Cole and Doctor Curtis.

Q Who is Doctor Cole?

A Doctor Cole is the Ph.D. and Doctor Curtis is the psychiatric consultant, they both were connected with the mental health clinic in Toccoa at that time; that's from their records. The next February 2nd, 1970, is a letter from Mr. McFarland to Nell Crisp, with a copy to Stephens County Department—Nell Crisp was the caseworker who supervised Jimmy in the Satterfield foster home. She was not connected with Stephens County, it was White County and she was the worker that supervised him. The next document has medical attachments with some psychologicals prepared [17] by our worker, Barbara Carpenter, which supplements the social study update for adoptive placement. And, this next is a copy of the last contact with Doctor Cole and Doctor Curtis.

Q When is that dated?

A June the 1st, 1970.

Q Do you know when the child was sent to Central State Hospital?

A In June, 1970.

Q Now, do you recall or is there any—are there any documents in that file pertaining to why the child was sent to Central State Hospital?

A In this particular file here, Mrs. Carpenter was our caseworker and she worked with the mental health clinic there in Toccoa. And, there is a copy of a letter that she

had sent to Mrs. Pittard here in the district, who was our Field Rep. at that time, stating that Mr. McFarland had indicated that there was not any—they had recommended institutional care and he did not know of any institution for Jimmy, other than Central State Hospital; this is from a letter from Mrs. Carpenter to Mrs. Pittard.

Q Do you have any records of any conversations concerning the same subject to that file?

A This is the one that substantiates it here, it's a recording of—caseworkers at that time made recordings [18] of contacts that they had.

Q And, what does that reflect—he was still in the Satterfield's home; is that right?

A Right; it was still hearsay. And, all of this time he was having trips to the mental health clinic provided either by our worker or a volunteer worker, or the worker in that part. This indicates that at one time, through Mrs. Pittard, that she had—since institutional care was recommended that we try the Village of St. Joseph or the Ethyl Harp Home.

Q I'll get to that in a moment. What I'm concerned about now is, is there anything in that record that indicates who recommended that the child be sent to Central State Hospital?

A This is in the form of the letter that came from Mr. McFarland at the mental health clinic, and the contacts with him and the Public Health Nurse about an application to Central State Hospital.

Q I'd like for you to be more specific. What does that page reflect concerning this?

A This contact on 6/1/70, worker talked with Mr.

McFarland at the mental health clinic, but he could offer no services for James. He did state that it would probably be better for James if he could stay with the Satterfields. Mr. McFarland says he knows it would be hard for anyone to [19] live with James since he is starting to express his anger and hostility outward, and this will probably increase as he gets older. He stated that probably an institution might be good for him as no one would be trying to establish a one to one relationship with him as they would in a home situation.

Q That's the Director of your mental health center there?

A At that time, yes.

Q And, was it at this time that you had him sent to Central State Hospital?

A Yes.

Q Now, let's consider the other steps that you all—is Jimmy on the—have you taken any steps to have Jimmy adopted, do you recall? How does that work?

A Permanent custody was given to our department in 1966, and actually when we have permanent custody of a child when we've been—you know the Court Order says for the purpose of placement for adoption. We then prepare what we call a social study on the child, you know, summary of life experiences, current health, emotional and social adjustments, paternal background. And, because Jimmy had had so many moves and problems, we made an urgent request to the state office to try to find a home for him for adoption, prior to him going to the Satterfields. So, once [20] a study is submitted it is supposed to be available for consideration at any time. This is on the state level.

Q So, the adoption procedure is on a state level and the county has nothing to do with it?

A That's right. The county's part is submitting the social study.

Q Now, before Jimmy being sent to Central State Hospital, were there any other institutional alternatives considered?

A Yes, we did explore—we wrote letters to the Ethyl Harp Home and the Village of St. Joseph. Those two institutions at that time, to our knowledge, would take children with problems such as Jimmys or an I.Q. level such as Jimmys. And, this record that I was just referring to also points out that Mrs. Luce, who was the admission counsel at the Ethyl Harp Home, happen to be in our office on another matter and she looked at Jimmy's records and said it's not likely that they could meet their program.

Q That was at the Ethyl Harp's Home?

A Right. That recording is in response to the letter we wrote to them.

Q And, that response is in this file, which is marked psychological?

A Right. Recording by the caseworker.

Q What about at the other institution you mentioned, [21] St. Joseph's?

A The Village of St. Joseph requires that there be a foster home situation for them to have their visits, you know, to return to on holidays or week-ends. And, we did keep the Satterfields in mind, because they were very fond of Jimmy and we wandered if this could be a resource

for him to, you know, have to go back to for visits. And, they said they could not take on this responsibility.

Q So, you had no foster home?

A No foster home and the institution plan fell through.

Q Okay. So, he was sent to Central State?

A Right, but we were in consultation with the people in mental health on this and this was the advice given. And, we talked to Doctor Charles Bush in Atlanta by telephone and told him the situation and then he called back and told us that Jimmy could go on the 25th. So, this was all in June of 1970.

Q Did you have any recommendations from any other person, other than this—is it Doctor McFarland or Mr. McFarland?

A Mr. McFarland.

Q Mr. McFarland. Were there any recommendations other than from his center that the child be institutionalized?

A I'm not familiar with that, unless I searched back [22] through the records.

Q Was that the primary you sought institutionalization?

A The children's unit at that time had just been established, the building at Central State, and this was the type of recommendation that—they were saying that they could treat children such as Jimmy. At this time they had to have an I.Q. of over seventy and they could deal with problems such as he had. Now, those regulations are changed now, but this was true in 1970, when Jimmy was there in '70.

Q Now, considering the periods since 1970, did you all make any efforts after 1970 to do anything with Jimmy?

A Yes,—may I add something?

Q Sure.

A When Jimmy was taken to Central State and went through the admission procedure, they did some more testing to see if he was eligible to be admitted. I'm sure after he got there, if they found out that he was ineligible, they would not have taken him that day, but they did go through this.

Q Let me phrase the question like this: When a child from your county is taken out of a foster home and put into an institution, what happens at the county level then concerning any future placement of him?

A Well, always the purpose of the county department when we have custody of a child is try to move him on into [23] something that is permanent. If it's temporary custody, work with his parents to get him back with his parents. If that doesn't materialize permanent custody that leads us to permanent placement.

Q So, you all are solely responsible for the child?

A Right.

Q Is an active file maintained on the child?

A Right. There is never a time our department should have a child hanging in limbo. I mean the purpose is to work toward permanency.

Q Is he assigned to a caseworker?

A Right.

Q Now, after 1970, can you tell us briefly what attempts were made on Jimmy's behalf to get him out of the hospital or to place him somewhere else?

A Basically, we kept the Satterfields still in mind for Jimmy, because they were real fond of him and I think it was really heartbreaking for them to let him go. They did have him back on visits. Each time there was a visit, holiday time, when he first was admitted, he did return to the Satterfields for visits in their home. The record indicates that in '71 was the last time he had a visit. So we checked back in the record and found out that he had been a disturbing factor during that visit and she had other foster children in the home. So she discontinued having him [24] back for visits, because he didn't seem to relate well with the other foster children.

Q Mrs. Satterfield had other foster children?

A Yes, after '71.

Q Do you recall how many she had?

A That was not a home in Stephens County, but from the record, I seem to recall that there were two girls there.

Q In addition to Jimmy?

A Right.

Q So, Mrs. Satterfield—this wasn't her only experience with a foster child?

A That's right. I believe at that particular time the last time he was there, he got upset and tore the screen door off and broke up some canned vegetables, and tore his own shirt off.

Q What other attempts were made to secure a placement that you recall?

A Now, I was checking the dates—we had a request in Toccoa, Stephens County, by some people who wanted to be boarding parents. So, during Christmas of 1971, we brought Jimmy to spend the Christmas holidays with them. And, this is unusual, I know, but after Jimmy visited with them, they withdrew their application to become boarding parents. Then we did try to find something else for Jimmy [25] and we always went back to the Satterfields, you know, to see if they would take him and we got a negative reply until 1974, but also during that time we had another couple in Stephens County that was interested in becoming boarding parents. Jimmy did not visit with them, but we did ask them if they would take him for one of his holiday visits, they said, no, that they would not be able to take him. So the next visit was back with the Satterfields in '74, this was summer of '74. And, continuing effort to follow any lead had always been in the back of our minds, because I did some speaking at Civic Clubs and carried some pictures of Jimmy at one time to a Civic Club meeting to see if we could solicit some interest for him as a particular child. He was referred to Child Service and Family Counseling through Mrs. Dixon in Atlanta, you know, for possible placement.

Q Well, I'll get back to that in a moment, I want you to go into some detail. Are the Satterfields not in Stephens County?

A No, they are in White County.

Q How was that placement arranged originally, do you recall?

A Through the district.

Q Through the district?

A Like we explained, you know, if we didn't have a

[26] place in our county, district, we would consult a Field Rep.

Q So, there has been some coordination through the district for Jimmy?

A Right.

Q Now, what efforts, when you were relating how you did this procedure, you said you went from the county to the district to the state; were any efforts made by the county to get him into the state placement system?

A Right. The one that I recall most was in '73, to Mrs. Dixon from Child Service and Family Counsel. Also during '73, we sent materials to Muscogee County for foster home recruitment for special children. This was an effort on their part to try to see what they could do to meet the needs of special children.

Q Muscogee County?

Q Yes.

Q Do you know any more about that program than what you just described?

A I just know that it was approved—the District Office, we learned that they were starting a recruitment campaign. It probably came through the state, that they would take any child with special needs through the state and do the publicity. We sent some pictures in that area of the state, because he was not known, with a short summary about him. This was sent to Muscogee County to be included, [27] but we had no feedback from that.

Q By no feedback, I take it you mean no offers to take him?

A Right.

Q Now, you also mentioned at the same time something about a state list; would you explain that?

A Yes. I understand that children that are hard to place or children with special needs, a small summary is prepared and circulated throughout the state through the Field Reps., it comes from the state office.

Q Did you refer Jimmy to the state for that purpose?

A Yes.

Q Is that reflected in your records?

A I don't believe it's in any of these records, but for a telephone conversation I had, I knew he was still considered on that list as of November of '74.

Q Now, is it your belief that Jimmy is still on that list—what is the state list, can you explain that?

A It's just a memo type thing that has children referred to by first name and their birthdate and maybe which county has custody, and just a brief description.

Q And, Jimmy's been on that list since when in 1973?

A As far as I can—feel like it's 1973. I thought I might have quoted that in this material right here, but I [28] don't see that I did.

Q Now, were there any other instances where during this period there were inquiries made to other institutions besides Central State?

A No, other than the Village of St. Joseph and Ethyl Harp's that I've already talked about. We did a special adoptive search that I haven't mentioned. The Casper home in Hall County and the Helton—individual parents.

Q Go ahead and explain that.

A This was through our district helping referring us to possibilities. One was the Casper home in Hall County, this would be adoption, and this was in a letter of June in 1972. And, then Helton was an individual single parent adoption and this was a White County man. Then there was also an inquiry into Franklin County, which would either be adoption or foster boarding care leading into adoption.

Q Do you know what happened to the possible placement with the Caspers?

A The letter in the folder from Barbara Griffin indicates that they were having some financial reversals at the time and would not be considered for Jimmy or for any child.

Q What happened to the single parent placement?

A This man lived next door to his family and would [29] rely on his family providing care for a child that he would adopt and his father died of cancer, so he withdrew, but anyway altogether.

Q So do you know of any other placements that have been attempted on behalf of Jimmy during this period?

A That's about all I recall, until it gets to this caseworker who is involved with him now. We didn't make any reference to those state referrals where we had one piece of evidence from District Three that they didn't have a home for James.

Q Would you explain what that is?

A That was one of the referrals statewide from the Field Rep. similar to this issued. Mitch Turner, you know, replied on a memo that he didn't have a home for a child such as this.

Q That's where your district refers to somebody else?

A Right.

Q So, there were responses from other counties I take it?

A Right.

Q Are you familiar with the Alpine Center?

A We know of the Alpine Center, it's not a residential center.

Q Did you investigate that as a possible—

A Yes, we found out it was not residential, it had [30] been suggested. It's to treat emotional problems, but it's not a school level and it's associated here in Gainesville, I think, in conjunction with Brenau College, but not residential.

Q Is that the third institution that you—

A Right. We grasped at most anything we heard about.

Q Now, I may have asked you, I'm not sure—do you ever stop recruiting for foster homes?

A No.

Q And, do you know if you have any children awaiting a foster home now besides Jimmy?

A We do not have any.

Q And, he is assigned a caseworker?

A Right.

Q Do you know if he has always been assigned a caseworker?

A Yes, this is a policy in our department to consider the case load. There is a card on each active child, it becomes the case load for the caseworker, assuming the child with their responsibilities.

Q So, on every active child there is a file and there is some sort of index card also?

A Statistical card, right.

Q Are there any reports that are filed by the department which reflect the existence or non-existence [31] of this child?

A Right, with a monthly report.

Q It's a file reflecting—

A Each child that we're responsible for and the activity of that particular child.

Q And, Jimmy is carried on each of these monthly reports?

A Right.

Q Are you responsible for those reports?

A The caseworker and a clerical worker.

Q I mean do they come to you or through you?

A Well, I see them once, but they are supposed to be accurate and prepared when they get to my desk.

Q Now, the third file that we haven't mentioned anything about concerns reports on Jimmy's behavior. How are these reports—and particular those that are filed in that file I just gave you—how are those reports prepared or by whom are they prepared?

A I need to go back, because procedures have changed, the current—is different. Back when Jimmy came into

care, the home county and the worker responsible for the case would prepare a narrative, social summary data, information that we may have obtained from neighbors or foster mothers. If the child was in another county in a foster home, Stephens County would not go into another [32] county, you know, to visit with this child. He became the responsibility for supervision for the worker assigned to supervise that particular foster home. The responsibility was that they would keep a case record and narrative pertaining to each visit, office contact, telephone call that pertained to this particular child and they were to share these records with the county of responsibility.

Q And, that's how those records are prepared?

A That's right, that was the procedure, back when Jimmy came into care.

Q How long was that the procedure, do you recall?

A Well, it was there when I came and I think it just has changed with this CSIS data control.

Q A recent change, when did this form—

A I think it must have been '74 or '73.

Q Based on your position as the County Director and your experience since 1963 with this child, do you have any opinion as to why you haven't been able to get him into a foster home?

A Well, mostly the records here indicate that he was given up, because of the behavior patterns and foster parents have been unable to cope with him. This is reflected throughout each placement that he has had.

Q Have the same problems been reflected in every home?

[33]

A It seems that even with visits, you know, he has exhibited some kind of behavior that has not been acceptable to foster parents. Now, I really have not talked to a lot of them just to say why can't you have him, you know, this way. They just have the right to choose to accept or reject a child we ask them to care for.

Q Have you observed any improvement, based on those reports, say in his recent visits?

A From the record it indicates that one of his visits that he had in '74,—he loves watches, this is a favorite thing of his and he got a little upset, he couldn't watch a special television program and went into a room and tore this watch up, and an electrical receptacle on the wall, he pulled apart.

Q And, he's still demonstrating these behavior traits?

A On one of the visits back to the Satterfields, he seemed concerned about a pair of shoes he had on and he reacted to this, about the shoes,—to destroy—

Q Are you all still attempting to place Jimmy in a foster home?

A Yes.

Q Have you made any attempts to place him in a home with persons with any particular qualifications?

A Actually, I don't think we've had any requests, other than the one that we had in '74. One of their references [34] when we got their application and we contacted references, they had had some experience with emotional children.

Q Who were those persons?

A Mr. and Mrs. Pritchard. And, this might be referred to Mrs. Schoonmaker later.

Q She was the social worker at that time?

A Right, she was the one handling it.

MR. LACKEY: I'm through.

MR. TARUTIS: Off the record.

(The parties went off the record for a brief period of time.)

EXAMINATION BY MS. LINDBLOOM:

Q Mrs. Whitaker, I would like to just clarify a few things when you were speaking about how you as a director of the local county defacs (DFCS) office would go about obtaining foster home placement for a child that was your responsibility. You mentioned—and what I would like to do is summarize what I think you were saying, if I'm correct, please tell me; if I'm not, you can just react to what I have to say. For foster home placement as opposed to adoption, the local county defacs (DFCS) office looks within their county as a first step; is that correct?

A Right. A foster home has to be an approved home. It means it has to have gone through an application process, studied, and met requirements, and already approved before [35] we place a child in it. Some of the homes are already in existence when we have a child to place in foster care.

Q And, the local county defacs (DFCS) office would go out and check out the home and would approve it or not, but would also be doing the recruitment of actual foster parents?

A Right. So it can be an on-going process. You can have an approved home and you can have homes in application status, you can have homes in study status. We use homes that are already in approved status.

Q But basically, most of the foster homes that you actually have that are developed within your county or developed by the local office or is it—

A By the local office.

Q You made reference to referring a case if you're unsuccessful at the county level to the state?

A No, to the district first.

Q What responsibilities does the district office have, what is your understanding of what they would do?

A Well, since the Field Rep. or—or Social Services Director—we might give them three titles, you know, keeps a master list. She delegates this to her secretary, because she is mostly here all the time and we would say, you know, we have so and so to place, age so and so, we don't have any homes in our county for this child, [36] would you give us a list of some vacancies, because most of the homes that are already approved, they know the age range that they can take. In other words, we wouldn't take a teenager and try and place him in a home, an approved home for infants. So, then she doesn't get into the aspects of behavior or social background of the child, she just gives us a list of vacancies. Then we would make the direct contact with the worker who supervises that home in the district level.

Q Okay. It's your expectation would be that once you made a referral to the district office, that you would be getting the names or possible sources back and you yourself would be making the contact?

A Right. And, the name of the worker who supervises the home would be given to us, too.

Q Okay, fine. What about further than that, beyond the district office, if you're still hunting?

A If we don't find a place for this child there within our district from one of the resources that she has given to us, we get back with the Field Rep. in some manner, you know, to tell her this didn't work out we need a place. And, then, she through—at that time the process would be that she would contact people in similar positions over the state to ask if—then give them some background information on the child, if they had a home to take care of [37] a child such as this. This would be across district lines.

Q You mentioned before to state offices. Now, is that the next step in this process?

A Right. Now, I believe since I said this—when this case came up and what current regulations are, are a little bit different. And, I think when Mrs. Taylor comes in she might give you what's current, but what I'm speaking about is what we might have done then, because I think now it is on a state level with the circulation list as I said, you know, circulating throughout other districts. You know the little summary and sent to Mrs. Dixon's office, but anyway it gets circulated one way or another. I think at the time we were working with Jimmy it was through the district level and like I might feel like—I might see another Field Rep. and say, you know, I have need of this, either by telephone—and she tried to stay as close to us so the transportation would not be a big problem. It's unusual to have a child in South Georgia, you know, boarded from North Georgia, etc.

Q At this point is it the person in the district office level that's initiating these contacts? In other words, you mentioned like Mrs. Dixon as a contact, would the district office person make that contact or would you again at the local defacs (DFCS) office do that?

A We would get the material together and it would be [38] according to whatever our Field Rep. told us to do. If she said mail it directly to Mrs. Dixon, with a copy to her, we would do this.

Q So the local defacs (DFCS) office then would strictly go by the recommendations of the district office?

A What they advised us to do. Now, in this particular file here on Jimmy is a letter that went directly to Mrs. Dixon, addressed to her.

Q From yourself?

A Right. Well, from our county office, the worker who was handling it at the time. And, that was for, you know, referral to Child Services and Family Counsel.

Q What was your expectation in writing the letter to Mrs. Dixon as to what her responsibilities or what her action would then be after a referral from you?

A Then we would expect that she handled it from writing or getting it to the proper source. And, we do have a letter, I think it's addressed to Mrs. Mildred Clark in Child Services and Family Counseling, enclosing this material.

Q Okay. So you said that you would expect that she would handle it from there?

Q Right.

Q In other words, that she would then—

A Make the contacts necessary.

Q Is this above and beyond, let's say, even the efforts [39] that the district office would make?

A Right. On up to another level.

Q Did you ever receive any response from Mrs. Dixon back, you know, to your letter?

A Not to our county, no.

Q Again, that would be just your assumption that once you made the contact with her—

A Could I speak from some previous experience from referrals that went like from our state office to Child Service and Family Counseling, that did bring some results, Child Service and Family Counseling then did get back in touch with us on their own, that did bring some results from a request. They made a call to us and said, you know, we understand you have this child. Now, I'm not speaking of Jimmy, I'm talking about something that did bring results.

Q Right, that's fine, I'm trying to understand now how the system operates. So, basically, from what you've said, you would continue—local defacs (DFCS) office would continue efforts for foster homes, that would be on a continuing basis?

A Right.

Q And, then if you were unsuccessful you then contacted the district office and if further help was needed you would make the contact to Mrs. Dixon?

A Right.

[40]

Q Again, to clarify that adoptions—okay, you were separating these that they are done differently, so the pro-

cedure is different for adoption. Now, as the local defacs (DFCS) office, could we just get that clarified what your first step is?

A We have to have permanent custody of the child, with the right to place it for adoption. We prepare the social summary, social data, background information and submit it to the district office, because we cannot search for a home for a particular child.

Q Is the primary responsibility then for recruitment in terms of adoption, we're speaking now of adoption, is that in the district office or is that in the local defacs (DFCS) office?

A It's mostly outside of the county level; it could be district or it could be state.

Q Okay. And, your understanding of the responsibility of a local defacs (DFCS) office would be to prepare, you mentioned, like the social summary and refer that in turn to the district office?

A Right. They would not have any idea that this child was available for adoption, unless they got the material from us. And, it has to have the verification of the child's birth, the court order attached that we do have the right to seek a home for him with the right place for [41] adoption; his background information summary of life experiences, social information, emotional problems, all the medical attached to it, any reports on psychological—

Q But, basically, recruitment then, in terms of any efforts that were made and in terms of an adoption, you know, on this basis, would be at the district office level as opposed to your own defacs (DFCS), local defacs (DFCS) level?

A Right.

Q Who makes the decision as to what type of placement to seek for a child—again, make the assumption the child is in your custody, who makes the decision? We've talked here about adoption, we've talked about foster home placement, who makes that decision?

A We have to either have a custody order from the Judge or a voluntary request from the parents to place the child.

Q Okay. In the case of Jimmy—maybe it would be helpful to come down to specifics—how was it decided as to the type of placement to seek for Jimmy?

A At the time he was brought into foster care, on the local level, he was an infant, we had a home that was approved to take care of infants in his age, you know,—

Q A foster home?

A —already set up. Now, infant homes—I need [42] to clarify that approved for infants, is from zero to two.

Q When we were talking generally before about the procedure for adoptions, when we were just speaking previously, you mentioned that this was basically that once you made your report, this is basically the district office responsibility, that they would do the actual recruitment for adoptive homes; is that correct?

A I don't think you would use the word recruitment, because people are applying for adoption all the time and we're doing studies, you know, for adoption and approval. They may seek through what is already approved to see if there is an appropriate home for the social study they have received on a child. Now, our understanding, for Child Service and Family Counseling, they have the

social study first and seeks a home for the child that is ready to be placed.

Q In other words, would the district office notify you of what efforts that they were making in terms of adoption?

A If it was it could be on just verbal conference type—you know, through contacts at conferences. This is where a lot of these are discussed, our problems and our efforts and our needs. We have conferences with our district level and particular where it becomes their problem area.

[43]

Q Specifically, in Jimmy's case, was a decision made to either choose to make efforts like for foster home placement or for adoption or for both?

A After he was in permanent custody it was both, either one that we had. We preferred adoption after he was available for adoption, because that request that went out before he went to the Satterfield home was saying please, urgent, you know, we need to get him into a permanent situation, rather than so many moves.

Q Okay. Then both were pursued, but adoption was preferred?

A Preferably, yes. You need to move a child into permanency.

Q Certainly. Are you aware of—to the best of your understanding or your knowledge, is the adoption search still being conducted right now and has it been?

A I don't have anything to substantiate in this record, but in our records that it was; but I understand there is a letter somewhere that Mrs. Poss and Mrs. Dixon were

agreeing to Child Service and Family Counsel, whichever home would be appropiate, if they could find either foster or adoption. This is in July, '73.

Q But to your knowledge, do you have any idea what has happened in terms of the adoption?

A Not now, no.

[44]

Q You mentioned in terms of your familiarity with J.R's case that you were a caseworker at the Stephens County defacs (DFCS) before you became director; is that correct?

A Right.

Q So you were familiar then with Jimmy's case prior to the time of his admission then to Central State in June, '70?

A Basically, until '68, would be my primary responsibility. From 1962 to 1968, I was the caseworker with Jimmy.

Q Could you explain a little bit more as to who actually made the decision that James was going to be institutionalized or the decision making process that resulted in that?

A I'm not sure that I would know the answer.

Q Could you be a little bit more specific?

A I think that I personally would have the knowledge of, you know, how that decision was made. I have just quoted from the records that the caseworker had contact with Mr. McFarland and he said, you know, that he would recommend institution. I did not have direct knowledge at that time.

Q You did or did not then have personal knowledge or involvement in that decision?

A Not directly, because the caseworker handles it and I'm sure that it was in consultation with our Social Services Director and the caseworker, and probably I was in [45] on it, but I can't recall, you know, the direct account of it.

Q Is there a procedure—in other words, is there or do you have any directives in any of your manuals or any guidelines that you have as to how a decision is supposed to be made by a local defacs (DFCS) office, such as admitting a child to an institution, assuming the child is in defacs (DFCS) custody?

A Well, other than what I had said and consultation with the Social Services Director.

Q It's your understanding that the Social Services Director would discuss this?

A Yes. And, we say this is the recommendation, you know, by our contacts.

Q Basically, then, the records you were quoting from was referring to the caseworker at the time; in other words, the records and things you were referring to—

A Right, were from the records, right.

Q You explained before now that James was in White County, the Satterfields were in White County, that he was in a foster home in White County, but he did maintain a Stephens County caseworker; is that correct?

A Right; her responsibility.

Q What was her name at that time who was the caseworker that we are speaking about?

A Let's see, probably—probably, two caseworkers [46] at that time, Mrs. Theo Bracewell, because I read in the record where she had provided some transportation for him at the beginning sessions of mental health and then she left and Mrs. Carpenter was the caseworker assigned to Jimmy. It was Mrs. Carpenter's records and recordings that I was referring to earlier.

Q So, basically, talking about Mrs. Carpenter's personal involvement, to the best of your knowledge, did she personally visit James, did she talk with him and visited into the Satterfield home?

A It's not the usual policy for our worker to go into another home to supervise, but she did have contact with him by providing some of the transportation to the mental health clinic. We either can do that or pay the foster mother to provide it, because he is our financial responsibility.

Q Okay. Let me just understand this. She did not have any personal—in other words, she did not go into the Satterfield home?

A Not as supervision, this was done by Mrs. Crisp and I think he had a couple other workers in White County at the same time.

Q You mentioned before that it was Mrs. Carpenter's records that you were referring to in terms of the times of admission?

[47]

A Right.

Q To your knowledge, did Mrs. Carpenter have any kind of training or any clinical or psychiatric training?

A No, I'm sure she was going on the recommendations of the mental health clinic, because if he was referred this is the people she would be using.

Q Is there anything in the record that indicates like any procedures that she might have gone through, in terms of getting—authorizing such a step? In other words, you mentioned the record that she did keep and the notations of telephone calls, was there any form that she had to fill out in terms of getting anyone's authorization, for instance your authorization to make the move that she did?

A No. I think the calls visit meant that she had voluntary placement agreement and we don't have a copy of that in our files, and I'm not sure if one was carried. I really do not know. I do know that from the record she called Doctor Bush, you know, in Atlanta, Doctor Charles Bush, and he made a call to Central State and said he could be brought on such and such a date.

Q Okay. I know this is a series of sheets, but can we move to the one where it starts up at the top telephone calls, move down, the next item down would be field trip, dated 6/24/70; do you see the page I'm referring to, up at the top?

[48]

A (Indicated yes.)

Q Could you read at the top where it says telephone call, could you read what that says there?

A Worker talked with Doctor Charles Bush?

Q Right. Yes, please.

A With the State Health Department about emergency admission of James for Central State Hospital. He

said he would check on this and call me back. In a few minutes Doctor Bush called and said he had talked with CSH and that we could bring James on either Wednesday or Thursday, June 24th or June 25th, between nine a. m. and four p. m. Doctor Bush said that since we have permanent custody of James, all we need to do is complete the voluntary admission form and carry it back with us. No Court Order is needed.

Q Okay, fine. To your knowledge, other than this was Doctor Bush ever sent a complete record or background on James? In other words, what I'm asking is, was there ever any personal involvement of Doctor Bush with James' case?

A That I do not know. If he's with mental health, he could have had access to the mental health records.

Q I would like to also refer you to something else we spoke of before and this is when you went through on the psychiatric evaluation, that folder, and you mentioned the cumulative running reports of the Stephens County Mental [49] Health Clinic in Toccoa had kept on James beginning in May of '69, continuing through on to his admission. You mentioned that Mr. McFarland, a recommenation from him—and we're talking now about the reasons and the basis behind James admission—in that report do you see the notation that begins 5/26/70?

A (Indicated yes.)

Q Could you read that, please?

A This is by Doctor Curtiss, a psychiatric consultant with the mental health clinic in Stephens County. This young man is having an acting out problem. He basically acts out in an agressive fashion and is sometimes almost uncontrollable in his behavior. However, he seems to have

made considerable progress and strength since staying in the present foster home. The present foster mother seems to take a very firm, but loving approach with him, which I think is very desirable. The difficulty in school I think has been that the teacher, which he has now, is not able to deal with his acting out behavior as realistically now as the one he had previously. It is my recommendation that he be placed in a school where there is a relatively firm reasonable displinary policy, which is consistently applied. I would also feel that it would be a benefit to him if he could stay in the foster home for an additional year since he has been in seven different foster homes, and I feel that [50] this must be very upsetting to him. If he has to move it would be even more upsetting to him. I do not feel that medication is indicated that would be of much value since as much medicine as would be required to tranquilize him would essentially knock him out.

Q What was the date of that report again?

A This notation from the record is dated 5/26/70. And, as far as I can determine that's the only time Doctor Curtiss saw him.

Q Was it your understanding either from the records or if you have personal knowledge, do you have a record of either Doctor McFarland or Doctor Curtiss initiating, making some type of request to you to place James in Central State, do you have any record that this is what happened or was being issued from Mrs. Carpenter to them?

A I think what would be done is that she would be in contact with them in discussing this case and for their recommendations, because I—this would be an opinion—that our workers would not go to the idea of Central State, unless it was given to us from somebody else for

the particular person. And, I read from this letter where she wrote to Mrs. Pittard indicating that she had been in contact with Mr. McFarland on June 1, 1970, but he did not know of any institutions other than possibly Central State Hospital.

Q You mentioned in there that there was a letter, [51] February, 1970, of Mr. McFarland to you, do you have that there?

A Yes. It's to Mrs. Crisp.

Q In the record that you've gone over and you've been speaking about now before, is there any other indication of any other information that Mrs. Carpenter might have used to make this decision to have James admitted to Central State Hospital?

A I really don't think that it was Mrs. Carpenter's decision, I think that it was recommended to her to follow through with the recommendation.

Q Who was it recommended to her by, do you have any documentation of that?

A That's the letter I read to you where she had just mentioned that she had written to Mrs. Pittard that she had been in contact with Mr. McFarland and that he did not know of any institution, other than Central State Hospital for James.

Q Are you referring now back to receipt of Mrs. Carpenter's notations of June 1st, where she said again a notation for telephone call, that she talked with Mr. McFarland at the mental health clinic, but he could offer no services, he did state that it would probably better for James if he could stay with the Satterfields?

A I'm quoting from a letter, which she has under her

[52] signature that she had sent to the Field Rep. She said I talked with Mr. McFarland about any suggestions he might have for James, but he did not know of any institutions, other than possibly Central State Hospital.

Q Okay. Basically, we're talking about the same date, the notation on here is also June 1st, 1970; is that correct?

A Right. But this is what involved in decision making, because we said we needed to bring in the Field Rep. on a decision such as this and this was her notification of this decision.

Q Do you have any documentation from Mrs. Pittard back to Barbara Carpenter that she authorizes or recommends admission to Central State for James?

A I don't think the word authorize is what we would need. I think there is a letter from Mrs. Pittard somewhere making some suggestions, but it's not in this particular folder.

Q Was there any written authorization or approval from anyone, other than what we have here in terms of Mrs. Carpenter's efforts, prior to the time of admission, the efforts that she made in the notations here, is there any documentation of anyone within defacs (DFCS), either at the state level or going down, who either noting approval of the decision or authorizing such a decision?
[53]

A As I say, I don't think the word authorizing is what we have and what we do. It was recommended to us and she was following a recommendation by contacting Doctor Bush in Atlanta to see if this was a possibility. And, he gave his approval stating that the child could be admitted and gave her an admission date.

Q Mrs. Whitaker, you had mentioned when you were talking about—when Mr. Lackey was asking about the

behavior folder and you were going through and speaking about that—you mentioned an improvement that your records had indicated, your records had indicated some improvements, and you mentioned, I believe, a foster home visit in '74, where James had exhibited some type of agressive behavior, whatever, acting out; is that personal knowledge or is that just that you remember from reading the records?

A This would be personal knowledge of Mrs. Schoonmaker who is here. This would be from the record, which would be recent, but she would be the caseworker that would be directly involved in this particular instance.

Q Are you aware of the Central State Hospital recommendations and reports of James' behavior and improvements since he was hospitalized?

A Is this the recent material that we got in November that we requested?

Q Well, specifically, that, but also on a continuing [54] basis since James has been placed in there; are you aware of the Central State Hospital personnel, their reports and recommendations, in terms of James' improvement?

A I think the only thing we have that's in writing from them is the recent one that we got back in November that I requested to update his material. And, then the last one I think that's in the record is in '73 that they sent us.

Q Okay. You have a report from '73, and then the next information is—

A The one we have in '75, right.

Q In your efforts within your county, or in the county,

to recruit for foster homes, within your experience, do you find that some children may be easier to place than others?

A Over the years, yes.

Q Could you elaborate on that and give us the benefit of your—

A Occasionally, there are children who are placed that maybe do not react to specific foster parents or specific foster parents may not react to them that maybe might be something different in school or on the playground, agressive behavior, acting out, that would cause them to ask us to move a child, but those situations are rarer than successful ones.

Q Based on your experience in attempting to locate [55] and work with foster homes, can you make any statement, in other words, as to like the age, is it easier to place like a girl than a boy, a two year old child as opposed to a twelve year old child; in other words, do you find—

A Very definitely. The younger the child, the easier it is to find a place. And, preschool, very definitely, easy. For school age children it's hard to find homes for and teenagers, it's just almost nil.

Q Is there any other—I've mentioned age as a factor there, is there any other factor that might come into play there, in other words, that would make placement more difficult?

A Well, it's been a good number of years since I've really has the direct contact, you know, but foster parents do seem to be more selective now than they did in the past when I really handled it. This is from, you know, problems that's coming across the desk.

Q Well, a child, let's say, that has a physical handicap, would that child be easier to place, harder to place?

A I think it depends on the handicap. In all the years experience, I've never had a handicap child.

Q Let's assume that you were going to be working to place a particular child, let's assume that was what you were setting out to do, if that child was presently in an [56] institution, do you think that would have any affect on whether it would be easier or harder to place that child, having been institutionalized?

A What we do is that we tell the people that we are contacting about his background and what it is, then we give them the right to accept or reject.

Q Do you feel, based on your experience, that the foster parents that you've come in contact with that that would be a negative factor in terms of their interest?

A At times it has, because we have to be honest with them and tell them what the problems have been and what the good points are. They need to be aware of this.

Q Do you think that going to the weight, in other words, of the child's present institutionalization, would that have any affect like if the child was young and institutionalized, would it be a drawback?

A I think it would be dependent—that would be pure speculation on my part and it would not be a definite answer.

MR. TARUTIS: Off the record.

(The parties went off the record for a brief period of time.)

MS. LINDBLOOM: That's all.

RE-EXAMINATION BY MR. LACKEY:

Q Counsel for the Plaintiff had you read certain [57] portions of that summary. Specifically, she had you read a portion beginning the fourth paragraph down from the top, styled telephone call. Would you drop down one paragraph, is this the contact you were referring to concerning the Ethyl Harp's Home?

A Yes.

Q Where was the child during this period, where was he located?

A He was still in the Satterfield's home and they had requested his removal, and these were in our efforts to find a replacement for him.

Q In other words, on 6/17/70, the Satterfields requested that the child be removed from their home?

A It was earlier than that, wasn't it?

Q Well, I was just looking at the log and what it says there.

A This is—the 6/17/70 was their decision that they could not have him back to visit with them if we did send him to St. Joseph's or this was the—our efforts to find another place—I'm not sure when the Satterfields decided that they couldn't keep him, but it's in correspondence and this reflects, you know, the activity that Mrs. Carpenter did in trying to find a replacement for him to go to from the Satterfield home.

Q And, all these attempts to place him in St. Joseph's [58] and the Ethyl Harp's Home all preceded your sending him to Central State Hospital?

A Right.

MR. LACKEY: That's all.

(Deposition concluded.)

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR EUGENE C. JARRETT, III, taken on the 4th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

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[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The signature of the witness was specifically waived by his attorney of record, DOROTHY Y. KIRKLEY, ESQ.)

EUGENE C. JARRETT, III, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A Eugene Coleman Jarrett, III.

NOTE: (Defendant's Exhibit Number One was marked for purposes of identification.)

Q Would you identify Exhibit One, please, Doctor?

A This is my curriculum vitae.

Q And you are a pediatrician, is that correct?

A Yes.

Q Are you a psychiatrist as well?

A No.

Q What is your present position?

A I am the superintendent of Southwestern State Hospital.

Q How long have you been superintendent?

A Since September 19th, 1973.

Q What is your role and what are your duties as superintendent of the hospital?

[3]

A To administratively oversee the programatic functions, with the programs directors to develop various treatment programs that the hospital is responsible for providing to the citizens.

Q Since you are a pediatrician, are you also the medical director?

A No, Doctor William Bailey is the clinical director. Doctor Bailey is a psychiatrist.

Q Okay.

NOTE: (Defendant's Exhibit Number Two was marked for purposes of identification.)

Q Would you identify Exhibit Two, please?

A Exhibit Two is a computer printout of information relative to patients admitted to Southwestern from its opening in 1966 till the present time, patients under eighteen years of age, with their dates of admission, date of birth, primary diagnostic code, and the type of commitment and their discharge date or whether they're still an in-patient, is there also included on this list.

Q And when was this list prepared, Doctor?

A This list was prepared approximately the middle of November, but up-dated Monday, which would have been December the 1st.

Q Was it prepared at the hospital?

A Yes.

Q And who in the hospital was responsible for getting this information?

A The department of administrative services unit, which operates a computer at the hospital developed the computer printout. The medical records section, along with my administrative [4] assistant, brought the whole listing up to date.

NOTE: (Brief off the record.)

A I might clarify on that, that those with no discharge date or no indication as in-patients, were not correctly listed on the computer. Only those with complete information were complete.

Q You mean there were some listed on the computer that weren't actually there?

A No, the computer read things—was not properly programed, so some of them are listed multiple times, the same patient. Some of them were admitted over eighteen, so forth and so on.

Q Did somebody go back and double check, and that's how you found that out?

A Yes.

Q Is that correct?

A Right, each patient was checked individually.

NOTE: (Brief off the record.)

Q All right, Doctor, would you explain again, the process by which the information on Exhibit Two was derived?

A We requested from the department of administrative services, computer section at Southwestern, a listing of patients admitted to the hospital under eighteen years of age. This listing was obtained and in cross checking, or double checking the entries, errors were found. These errors have been corrected on the computer listing. Basically any line listing, or any entry of a patient, date of admission, date of birth, diagnostic information, commitment code and discharge date, has been verified. Those with discharge dates, commitment code changes, reflect corrections of the originally received computer information.

[5]

Q And seventeen is the commitment code for voluntary patients under age eighteen, admitted by their parents, is that correct?

A Correct.

Q And have you double checked to make sure that all of the seventeens show up on this list someplace or another?

A Right, as best we can determine, they're all here, through our double, and in several cases, triple checking.

Q And that—the double and triple checks were done manually, is that correct?

A Yes.

Q Would it be possible to have the computer program corrected?

A Yes.

Q How long would that take, do you know?

A I really can't answer. I might mention, also, that some patients were admitted to our hospital prior to our having a child and adolescent program, their need for children's services being obtained then, through the program at Central State Hospital, their discharge date may have been from that program, and it's indicated as "Discharge CSH" and the date.

Q Would they have been transferred back to you?

A Not necessarily at that time.

Q You mean you—for a part of the time your child and adolescent case load was physically at Central State Hospital?

A Correct.

Q And so they would handle the discharge?

A Yes.

Q How long has the child and adolescent program been in operation at Southwestern?

[6]

A We began efforts when I arrived in September, '73, to obtain a program—funding for a program. We obtained this through a Federal grant. After training staff, the patient admission aspects began in April of 1974.

Q Do you have separate child and adolescent units, or is it all one unit?

A One unit.

Q And how many patients?

A We have a maximum capacity of twenty patients. We presently have twelve patients.

Q Doctor, what are the general admission procedures used for children and adolescents?

A Very simply defined, the child is admitted through a community program. To explain that further, it is our feeling that children should not simply be admitted directly to the hospital with no definite effort put forth to take care of the child's needs in the home, not only for the child's benefit, but because many times the child's problems are an integral part of a family problem situation. So any referral for admission is first of all processed, or evaluated, by community mental health people, and then, if institutional admission is to be considered, the institutional staff is involved in a final determination of what the treatment plan will be for that child, and that

child's family. It may then include a short term admission, or an admission to an institution for the child.

Q Okay. Do you ever admit children without them having previously been seen by a community mental health service?

[7]

A We have not at this point. I can't, of course, say what the future will bring, but we have received direct referrals from Juvenile Courts, Department of Family and Children Services, and other individuals. Our first step is to get the community mental health program, child and adolescent representatives, to hook them in with the referring agency or individual, to initiate this evaluation prior to admission. Or prior to a consideration for admission.

Q As superintendent of the hospital, what is your relationship with the community mental health programs in your area?

A Very close, really. We are working on and have worked—succeeded to various degrees, with a similar process of this as far as adult patients are concerned, also. We have a very close working relationship with the community mental health in all areas of our service area.

Q Are you familiar with what the evaluation process would be in a community mental health center?

A For the children?

Q For the children, yes.

A This would include a social evaluation of the home situation, possibly—probably an evaluation of the child's school situation, psychological testing to indicate—or as

part of the evaluation. The social evaluation would be a look at the family, its arrangements, interactions, financial needs, and everything, and out of this would come, really, not just a plan for the child, but more than likely a plan for the whole family, as an effort to help the child.

Q Do you know in what percentage of the cases the family as well [8] as the child, is treated in the community program?

A I can't give you an exact percentage, but I would—from the cases that I have reviewed in our program, I would say better than ninety percent, if there is a family. I think with all of the cases we have now that have families, that the family members are involved in some kind of community mental health program, while the child is in the hospital and returning home.

Q What efforts do you use to make sure that the parents are involved in the treatment program?

A Varying efforts, really. First of all, it's just to try to help them understand why the need is there for this to happen. If this is unsuccessful, and if all the members of the helping agency group that are involved with the child, see the family as resisting, then they would become involved in whatevery way is appropriate to make sure that the child's needs are met. And the Department of Family and Children Services is frequently involved in this type of situation.

Q What would their involvement be?

A Well, they would be sometimes the referring agency for the child to begin with, they might be asked for assistance for the family if the mental health people saw the family needed this and the family had not been able

—had not obtained help before. They would be brought in as an additional assistance group to try to help resolve some of the family's problems. If they see the family as not being the proper place for this child, then, of course, it is part of their responsibility to work to correct this, and on some cases, it has meant that the child—D.F.C.S. has, with the assistance of the Juvenile Court, helped the child to [9] find a better place to live, and this has been a part, then, of his betterment of his mental health situation.

Q After the evaluation takes place at the community mental health center, is an effort made for treatment to be given to the child at home?

A Yes. This is the whole thing most of the time. The evaluation occurs there and the treatment is initiated and accomplished there. That's why I mentioned earlier that only those children, where institutional care and treatment is thought to be—or going to be a part of the child's need, will the hospital staff become more intimately involved in this pre-admission planning. Now, they may be brought in as consultants on cases that will remain in the community, but they are always part of the pre-admission planning for any child, where this institutional admission is to be considered. In some cases, the institutional admission will never occur, because the final outcome of all the planning is that it can be accomplished in the community, and it is accomplished there. But before the child gets to hospital, everybody to be involved with his case has been involved, and agrees with the decision to be made, and has been a part of the development of his treatment plan.

Q Just in a general way, what factors would enter

into a decision to hospitalize the child, rather than trying to treat him at home?

A Oh, certain things such as medical needs. You many need the child—if he is overtly psychotic, it may be that the medical decision that he needs to be in a situation where he can be watched extremely closely while medication — medical treatment [10 "A"] is inititated for his psychosis. And once he is stabilized, then he would be returned—once the medication regimen is stabilized, he would then be returned home to continue this. It may be that the family situation has been so disrupted or disruptive to members, that a brief separation is necessary to allow the community people to help the parents to begin to learn how to deal with the child while the child is in the institution, treatment routines are established to be applied in the home. Sometimes separation is just necessary to begin to get an accurate view of the situation and to develop a treatment process.

Q Would that last factor be particularly prevalent in cases of behavior disorders?

A I can't really say whether it would be more prevalent with behavior than with psychosis. It would occur more often, because there are more behavior disorders than there are true psychoses, probably.

Q Do you have any rough idea of the percentage of children admitted with behavior disorders?

A In our program at the present time, it would have to be an estimate, but probably eighty percent of our program, patients thus far, have been behavioral disorders as opposed to psychotic children. What we think we see is the program becoming better known through the region, more psychotic children are gradually increas-

ing. Maybe they're better identified, or whatever the reason may be.

Q Do you know what the average length of stay is on the children and adolescent unit?

A At the present time it's around sixty days.

[10 "B"]

NOTE: (Defendant's Exhibit Number Three was marked for purposes of identification.)

Q Would you identify Exhibit Three, please?

A Exhibit Three is information copied from the records of the patients in the institution under eighteen years of age on December the 1st, 1975. This is not a complete chart, but what we felt would be pertinent portions of the chart.

Q What does it include for each person?

A It includes the admission summary, which is the face sheet, including administrative and other data; it includes the referral form which is used by the community to refer patients to the in-patient program at the institution. It includes a psychiatric admission note; it will include a social service summary; and it will include other things depending upon the individual case, the treatment team meetings, treatment plans, progress notes, and a discharge summary, if the patient has been in before and is returning, and information of that type.

Q Okay.

NOTE: (Defendant's Exhibit Number Four was marked for purposes of identification.)

A I might mention I have indicated that two of these patients, in the upper right-hand corner, it says two

hundred not in C&A, these are individuals who are seventeen years of age, and because of their maturity, they are not housed in the child and adolescent program.

Q Are there some seventeen year olds that are in the child and adolescent program?

A Not at the present time. The program is basically limited to [11] children sixteen and under, but with the flexibility that if you have a child who is seventeen, or even older than that, possibly, whose physical maturity and personality maturity is not to the point where he should be involved in the adult program, he would be involved in the child and adolescent program.

Q Would you identify Exhibit Four, please?

A Exhibit Four is briefly described, a referral process for community mental health programs to use in the referral of patients for admission consideration.

Q And it states in writing basically the policies we've been discussing, is that correct?

A Correct.

Q Once a child is admitted to the hospital, what type of reviews are made of his case after admission?

A The treatment team, which includes not only people at the hospital, but also child and adolescent representatives in the community, would be involved with this child and his family. They review the child's situation minimally of once a month. The hospital treatment team reviews the child's situation minimally once weekly. These reviews follow an outline—follow—reviews of the child's treatment plan, which is developed according to a specific outline, to assure that all the parts are covered. This review, will, in the course of the child's treatment,

include his progress relative to visits home during the institutional stay, as well as his progress within the institutional program.

[12]

Q Now let me understand, there are two separate reviews, one conducted with community staff involved, and one conducted by the hospital staff?

A Correct.

Q And the hospital staff reviews are at least weekly?

A They will be more frequently than the total team review, because of travel and other problems in getting the team together—time problems; but that's correct. The team involved intimately with the child in the institution reviews the plan weekly. The total team, which is the team involved with the child's family as well as the child in the community, and the institutional team, review the whole situation minimally once a month.

Q Is there ever a review conducted by hospital staff that are not directly involved in the case?

A Not at the present time. We are trying to work out some mechanism to accomplish what is commonly called utilization review, where third parties, or non-involved representatives, review the programs, not only in this situation, but in others. The only outside review at the present moment, would be the Division of Mental Health staff members, who would review the function of the whole child and adolescent program. This occurs minimally once yearly, when the grant for the program is reviewed for renewal, and more often depending upon their travel capabilities to visit the institution.

Q Would they review individual cases at that time?

A As part of this, yes. They would not review every case, but could select cases at random for review.

Q Would they particularly select cases that have been there for [13] any length of time, longer than six months or longer than . . .

A Not necessarily. Of course, we don't have any cases of that type at the present time. I don't believe we have any child that's been in this program six months.

NOTE: (Defendant's Exhibit Number Five was marked for purposes of identification.)

Q Would you identify Exhibit Five, please?

A Exhibit Five is the outline followed—to be in the development of the patient's treatment plan.

Q Okay. While a child is an in-patient, is his family still being treated in the community?

A Yes. The family is involved in treatment in the community, the child will go home and stay with the family on weekends as often as is possible. What we have in some cases, is the child stays within the hospital program Monday through Friday and goes home every weekend. This is two reasons, one to maintain the involvement of the family with their child; the second reason is to be able to assess the progress that the child is making —and the family is making in being able to deal with the problems that they have to deal with, and modifying the treatment programs as indicated by the success or lack of success on these visits.

Q Do you find in general, a reluctance on the part of parents to take their children out of the hospital when the staff recommends this is the best plan?

A No, not really. Not if they understand that this is the way the program runs at the very beginning. The exception being, of course, the parent who does not wish to have the child in [14] the home to begin with. This type of problem would be identified in the evaluated phase, attempts made to work with it, and if it cannot be resolved, it might be a situation where another family might be better for the child.

Q So what steps would you have to take if that situation arose?

A This would be taken by the Department of Family and Children Services through the Juvenile Court system. They would have been involved, in other words, enough with the case to know the necessity of this action.

NOTE: (Brief off the record.)

NOTE: (Defendant's Exhibit Number Six was marked for purposes of identification.)

Q Would you identify Exhibit Six, please?

A Exhibit Six is a very brief description of the child and adolescent program for this twenty-four counties in southwest Georgia that we are responsible for.

NOTE: (Defendant's Exhibit Number Seven was marked for purposes of identification.)

Q What about Exhibit Seven?

A Exhibit Seven simply defines some guidelines which we—which are used in our involvement with the psychoeducational center program in that area. The psychoeducational center being the community educational program for children with emotional and other problems. We have a teacher within the child and adolescent unit at the in-

stitution, but the patients—is an attempt to assure that, as part of their treatment, we feel that they need to be involved in an educational program. So we have the in-patient program as the—for those who cannot [15] compete in any kind of community program, and then as soon as they are able to leave the institution educational system, they go to this community program; as soon as they can leave that, then they go to a special education program in the—in a public school in the area; all of this being preparatory work to try to help this phase of their development, so they will be able to easily re-enter their school system when they return home.

Q One of the contentions in this case, Doctor, is that voluntary admissions of children to hospitals should be preceded in every case by judicial proceedings. Is it your opinion, as superintendent of a hospital, that judicial proceedings in the admission of children would be beneficial?

A No, I don't really think so, not with the system, particularly, that we have in operation here. What we have found, is that when we have been contacted by the juvenile authorities, when they found that there was available for their use, community mental health assistance for this child and this family, that they were pleased to know this, and used it, and use it appropriately. They can be of help, of course, when judicial assistance is necessary to get things done that need to be done, but I don't feel that in every case they need to be involved.

Q As a pediatrician, is it your opinion that judicial proceedings might have any harmful effect on children?

A That's a difficult question to answer, really. If the judicial proceeding involves trials, court appearances, things of this sort, then I certainly feel this could be very

frightening to the child, unless handled in a definitely very appropriate [16] manner. Children see things — maybe based upon what they see on television and in movies, but they do have opinions or thoughts about court and what all court involves. And a court hearing can be handled in such a way that it does not frighten the child, I'm sure. I also think that it could be handled in a way that would frighten the child and could actually aggravate problems rather than help them.

Q Have you attended any judicial proceedings yourself?

A No.

Q So you're not . . .

A So I can't—as I said, I can't really answer the question but just except my own personal feelings.

Q That's all the questions I have.

EXAMINATION BY MR. GRANBERG:

Q Doctor Jarrett, you were saying, when we had some problems about this computer printout, I think you said it was originally incorrectly programed, is that right?

A (Nods in the affirmative.)

Q I just want to ask you about a couple of them—of the things that are on that in regard to another statement I believe you made later. I'm not—I don't want to put words in your mouth. I believe at one time you said the longest anybody had been there, the present people, is six months?

A In the present C&A program since it developed in April of '74.

Q The longest anybody has ever stayed is six months?

A In the C&A—no, I don't think we have anybody in the C&A program that we have, who has—that have been in it for six [17] months. Now we may have, in the older patients in the hospital, people who might have been admitted under eighteen, who may have stayed in the institutional program for more than six months.

Q Okay. Do you know—there may be people who were admitted under the statute—the statute we're talking about, when I refer to that, will be 88-503.1, the voluntary admission statute, . . .

A Right.

Q . . . that there may be children in there who were admitted pursuant to that statute, before the children and adolescent unit came into being . . .

A Right.

Q . . . who are now in the children and adolescent unit?

A We have one boy that you have information on that is in that program now, that had been admitted to Central State, and I think had been admitted to Southwestern, prior to having the child and adolescent program. But of those in the program now . . .

Q Now, let me just—I think this is one—maybe you can explain it . . . Okay. What we are referring to is one of the pages on the patient listing, and if you could just look at that for a second and tell me if—is this person now in the C&A unit?

A Which one are you pointing to?

Q This one right here, I'm sorry.

A This one right here?

Q Yes.

A That person was discharged June the 27th, 1975. The next one [18] should be an in-patient.

Q I'm sorry, I meant—I was referring to 3322.

A Okay. That person would have been admitted November the 22nd, 1972; this person would be an in-patient now. This person is not in the C&A program according to her birthdate.

Q I see.

A She would be seventeen, I believe, so she would be on an adult unit.

Q Okay. Would you just look at this one and tell us about that. I think this is it, 3534.

A Okay. That's an in-patient—this is a mental retardation diagnosis.

Q Okay, that was our mistake. That was the wrong number. Okay. But there are—I don't want to over-state this, but there are people, then, who were admitted pursuant to the statute who have been there longer than six months, and are somewhere in your hospital, and are under, at the present time, eighteen? For example that one—the first one that we just discussed. She may not be in the C&A unit, but she is under eighteen, she is in the hospital . . .

A According to that data that's correct, but I'd have to calculate her birthdate to see whether she is still under eighteen or not, because this information here is supposed to be only the patients that we have . . .

Q Okay. Without trying to pin you down too much, is it possible that there are people who were admitted—children admitted under the statute and are now somewhere—not necessarily the C&A unit, but somewhere in your hospital, and are under eighteen?

[19]

A It is possible, but I would say that these would be people who are over the age range for our present C&A program; in other words, seventeen.

Q Why is the cut-off sixteen? I guess I should—up to sixteen. Why is it . . .

A At the age of puberty, many things change in additon to a person's physical being. Attitudes change along with this, personalities change, and do forth. In our efforts to develop a child and adolescent program, since it is small, and since we didn't have any funds to develop the broad range thing, we felt that it would be necessary to try to keep the population in the program, one that would not be disruptive to itself, in other words. And to mix too many different types of people together, we felt would mean that the patients themselves would be detrimental to one another.

Q I can understand that premise, or the dichotomy there, the cutoff line.

A That's why I said earlier, too, that though the program states, I think, on the program description, generally sixteen or under, something of this sort, we retain the flexibility within the program to have anyone, even eighteen or—theoretically, even older than that, whose personality is being—is more in keeping with a child or adolescent program. If that type of treatment is what they need, then we have no hard and fast rule that says they cannot be included in this program.

Q No age limit at all. Do you have any—do you have any people now who are seventeen years or older in the children and adolescent unit?

[20]

A I think we have one boy who is either seventeen or almost seventeen.

Q Okay. Have you had any, let's say, in the last six months with the exception of that child? Have you had any children seventeen or older in the children and adolescent unit? Or in the last year?

A Right. I can think of one child that I think was seventeen. Others, the program staff has been involved with, they may be living on an adult unit, but coming to the child and adolescent program on a day basis.

Q Assuming, then, what we were just talking about, would it be fair to say that although the program—your hospital does say that it has no end limit to the people who could be in the children and adolescent unit, if doctors—physicians deem that treatment there would be most beneficial to that person, that there have been none, or few, children—children or adults seventeen years or older who have in fact been admitted as full-time patients to the children and adolescent unit?

A Few, correct.

* * * * *

[24]

* * * * *

Q Let me ask you a few questions about your specific institution—hospital. What is the total number of people, approximately, in the hospital right now?

A Total number of in-patients would be about five hundred and ninety.

Q And—so right now there are—how many people in children and adolescents, approximately?

A Twelve or fourteen at the present moment.

Q And the other ones are adults, voluntarily committed or involuntarily committed?

[25]

A There would be adults, both voluntary and involuntary, and mentally retarded—we have one unit for mentally retarded, a hundred and twenty beds. This is for individuals who have medical nursing care needs, physical handicaps of a severe degree.

Q I see. The—in regards to your staff, how many physicians do you have, the number of physicians?

A Presently on board we have fifteen, I believe it is.

Q Now on board, is that a term of art . . .

A That means working.

Q Okay. The doctors, how many of them are licensed to practice in Georgia, do you know?

A Nine.

Q And then the remainder are—I forget, Doctor Skelton yesterday gave us the correct terminology . . .

A They have a limited license, institutional permit.

Q Institutional permit.

A To practice within the institution.

Q So is that true, that the remaining six have an institutional permit?

A Yes.

Q Do you have any American Board of Psychology and Neurology certified psychiatrists?

A No, all of our psychiatrists would be what are called board eligible. They are not board certified.

Q Do you have any child psychiatrists there?

A No, we have one consultant child psychiatrist, who consults on particular cases.

[26]

Q Who is he attached with?

A He actually comes from the University of Florida at Gainsville Medical Center.

Q How long has he been there?

A Not very long. I can't recall exactly how many visits or how long. It's just been within the last, say, six months, probably.

Q On the staff, are there any foreign born or foreign trained physicians or psychiatrists?

A Yes.

Q How many would you say foreign trained phychiatrists are there?

A Two.

Q I don't know if I asked this, please forgive me if I'm repeating it, but how many psychologists—psychiatrists are there?

A There would be—as I mentioned earlier, the clinical director is a psychiatrist, we would have five.

Q Five psychiatrists?

A Uh-huh. (Affirmative.)

Q And two of those are foreign born or foreign trained?

A Well, not totally foreign trained. One of those was trained at the University of Virginia. His foreign medical school training was in the Philippines, but did his psychiatry residency in this country.

Q And the other?

A He did his—if I can remember his credentials correctly, I think he did his psychiatry training in the Philippines, but has also done some work in this country.

Q So both of them are—both doctors . . .

[27]

A Partially, right.

Q And how long have they been there?

A Oh, just two or three months.

Q Are all the psychiatrist—I should say, how many people are involved with admitting children to the hospital under the statute which is the subject of this litigation?

A Okay, at the present time, as mentioned, the referral system we now have in place for children, would require that the community mental health people be involved, their psychiatrist, Doctor Middleton, who is a psychiatrist for this program, and so forth. In other words, the whole treatment staff would be involved in the admission decision. So it would not involve, generally speaking, anybody except the child and adolescent people.

Q Well, who actually makes the decision? I mean, does one person make the decision on the advice of others, or is it a two out of three, or something of that nature?

A It's not put to a vote, I don't think, but the decision for admission must be made, in the final analysis, by a physician according to Georgia law as I understand it. The physician, . . . in an interdisciplinary team approach to evaluation and treatment, so the physician participates as a member of this team. He has the authority to over-ride any decisions which, in his medical judgment, are inappropriate. So if I understand your question correctly, the physician would do this.

Q And all of the fifteen physicians on your staff are able, not only on qualifications, but by the way you've got them on the staff, be able to admit people? I mean, is anybody especially [28] assigned . . .

A Theoretically, yes, but in actual fact, with this program, if they receive a referral for a child at night or on weekends, then they will either refer this child to the child and adolescent program for the evaluation regarding admission, or will call in the people in the C&A program on call to assist them with handling the situation appropriately.

Q So no decision to admit is ever made by . . .

A By whomever happens to be on call?

Q Right.

A It's difficult to say something never will happen, but in this case I think I can say yes, that's true.

Q How long has this team approach to admissions been in existence?

A Since the program began in April of '74. It is being further clarified and developed, of course, as the new people get experienced.

Q It sounds, from what you're talking—your general description of programs—you have a pretty close working relationship with these mental health centers?

A Right.

Q And do you know which or what—what the staff consists of in each of those institutions, or . . .

A Each community mental health center has a specific component of their staff defined as a C&A—child and adolescent—representatives. These are the people that directly interact with the institutional staff. These are the people that are responsible for either providing or seeing that services for families as needed as part of the C&A program are obtained. [29] I can't give you the specific backgrounds on each of these individuals.

Q Well, you did mention like Doctor Middleton?

A Doctor Middleton is the director of the Archbowl (Phonetic) or Thomasville Community Health Center.

Q And are there psychiatrists in each mental health center?

A Each mental health center has a psychiatrist as a member of their staff. There are—I do know with the Thomasville Center there is a Ph.D. child psychologist, a child psychiatrist social worker, a recreational activity therapist-type person involved with their child and adolescent program. In the Valdosta Center, I believe their chief representative is a—I think he's a social worker—two social workers basically make up their key team members.

Q Okay. Let me just ask you, just pick out any of the counties—like if somebody wanted to—a parent or

guardian wanted to admit his child to the institution, and he called up your hospital, just what would happen?

A If he called our admissions office, which I would assume would be their contact point, since it's listed in the telephone directory, then the admission person who received this call, in gathering the information would recognize the fact that this was a child. They would then ask the people to hold while they transferred the call to the director of the child and adolescent program, or the staff member that was handling—receiving calls if the director was not in place at that moment. These people would then gather the information, talk with the parents, and then make an initial assessment as to where things needed [30] to go from that point, which as a general rule would mean that they would tell the person that someone would be in contact with them shortly. They would then contact the community mental health center representative for that area, and that same day they would begin to receive some contact from the community, initiation of the evaluation process. On occasion, the paramount need might be in something other than mental health. If this were the case, then this worker would also make contact to another helping agency, or what other group needed to be involved with this family as well, now instead of, but in addition to.

Q Okay. Let's say they still felt—the parents still wanted the child to be admitted to the hospital. Would the psychiatrist or some physician at the community mental health center then interview the child?

A Oh, yes, the child and the family would be evaluated by the community component of the system.

Q And that will always happen, they won't come directly to the hospital . . .

A Theoretically, this is the way it's set up, this is the way it has worked. Now on occasion, I can imagine someone . . .

Q I'm talking about non-emergency situations.

A Okay, yes, this definitely is the way it works now.

Q It sounds like, then, that your staff is in pretty frequent contact with the people at the various mental health centers?

A Right.

Q Do you know if a psysician, or a psychiatrist, whoever it is at the mental health center, that would say, yes, this child needs to be admitted, would that decision be—generally [31] followed by the hospital admitting crew or team, at your hospital?

A I would have to say generally I suspect it would be, because this decision would have been made, again, by the teams together. The pre-admission planning requires that the hospital staff is involved with this community group in determining the child's needs, and whether or not the hospital program has the capability to address these needs.

Q Okay, let's say we've got the recommendation at the community level, and then the child would be referred to the institution—to the hospital?

A Right.

Q And at that time a separate interview would be conducted by a physician at the hospital? Or would a team meeting then take place?

A A team meeting would have taken place prior to the child's coming . . .

Q I'm sorry.

A . . . and then further, after the child is admitted, more detailed, more in-depth work continues to go on, the development of a treatment—modification of a previously developed treatment plan and so forth and so on.

Q Okay. I just want to make sure I have it straight for admission. Pardon me if I'm repeating things. If the doctor recommends—from the mental health center, that the child should be admitted, then does a physician or psychiatrist from the hospital go on out to the mental health center and do the—does he [32] meet with the team at the mental health center?

A The psychiatrist? Not necessarily.

Q Essentially what I said, is the one who eventially puts his name on the admission sheet at your hospital . . .

A He will not necessarily, in person, interview the child in the community. He will have reviewed all of the data that has been collected on the child and the family situation and so forth.

Q Okay. I'm going to try to summarize some of this, and if it's incorrect, please stop me. A child comes—parents come to the mental health center or to the hospital—they're at the mental health center or the hospital refers them to the mental health center, there is an interview then, by a physician at the mental health center to determine whether—what the problem is, and what type of—whether recommendation for admission should be made, the . . .

A The physician and other staff.

Q Okay, who would the other staff be . . .

A It would be social workers and psychologists, generally speaking, to do psychological testing, social assessment of the family and so on.

Q The psychologist would probably do the testing about the time they did the interview, or . . .

A Not necessarily the same day. In other words, the evaluation process in the community may take several days, or longer.

Q It could take a while, then?

A Oh, yes.

Q I can understand your concern — obviously you show concern [33] that the child not be admitted just for any reason.

A Uh-huh. (Affirmative.)

Q Okay. So you've got a—this thing going down at the community mental health center, and you've had a psychological test. The social workers—I don't know what you call them—whatever they are, who are connected with the center, I imagine they go in and look for secondary information from schools, neighbors, relatives and things like that?

A Correct.

Q And then they would write up a report and give it to the psychiatrist or the physician at the mental health center?

A Yes, the team involved with this case would review the case, all the findings and everything would be discussed by the team in a conference, so to speak.

Q Do you know what order that would happen? Would the interview of the child by the psychiatrist take

place, and then information gathered by the social worker, or would the psychiatrist make his decision or recommendation based partially on the interview and information he has received previously from the social workers?

A My assumption would be that it's based on his interview and the information—additional information he had received.

Q But you don't know what chronological time sequence that occurs in, do you?

A No, I don't.

Q Okay. So then at that time you've had—the team meeting would be the three people there and whoever is—whoever is in [34] contact with them, either physically or by telephone, or I guess by even letter, at the hospital. And that would be just one person, the psychiatrist at the hospital?

A No, it could be more than one person. This would be one of the functions of the at least monthly meetings of the hospital and community staff together, review of current patients and review of problem cases where institutionalization might be considered.

Q I'm only talking about admissions, now.

A Well, this would be a combined staff function.

Q Okay. So there could be, in an effort to make sure that the—apparently to make sure that the child's treatment plan fits his particular situation, there could be a pretty good passage of time before the decision to admit is made, not for the purpose of delaying it . . .

A Possibly.

Q . . . but for purposes of making sure.

A Correct.

Q Okay. Would—considering—I would also make the assumption, then, that you—the hospital and the community mental health people that you work with, consider it extremely important to get as many facts, or as much information about the case, both the child and the family, as possible, before any decision is made as to either diagnosis or admission?

A Correct.

Q Then assuming the thoroughness of the plan, would the admission procedure to the hospital be burdened in any significant degree, let's say, by the intervention of a third party, an independent [35] third party like an arbiter, or even a Probate Court Judge, or a Judge, at which point all of this information could be set in front of him, realizing, of course, what you previously said on direct about your qualms about judicial hearings.

A The only thing that you've already said, is that this is an additional step, which would, of course, take time. As far as I'm concerned, in this program, there would be nothing to hide. I don't see anything to be gained, really, either.

Q Well, don't get me wrong, I'm not trying to say—I can see your concern, and I'm not trying to say that we—we're suggesting this because you're trying to railroad a child, but considering that—could you agree with me that it's also sometimes very helpful—like you talked about the team review, you must agree that it's good to interchange ideas and facts, because of your team approach.

A Uh-huh. (Affirmative.)

Q And it might--and since the admission process can sometimes take a while because of your concern that—a situation where the people from the hospital got together with the other people from the mental health center, could also be an avenue for an exchange of ideas, information and perhaps, discovery of alternatives which maybe they didn't know existed, and this independent arbiter, Judge, Probate Court person, somebody else could say, maybe this exists?

A If I follow what you're saying correctly, in many of these cases these people are already involved, because the referral may have come from them to begin with.

Q Surely.

[36]

A And they have referred the case maybe because they did not have the answers, and they needed the assistance provided by the mental health component.

Q I guess what I'm getting at, assuming that they don't have the expertise off-hand to make a decision, you know, even if they didn't have the priority or jurisdiction to make that decision, but assuming if they did have that power, would it hurt if, you know, if they say that the court referred somebody—tried to get as much information as they could, and say, as a matter of protecting the child's liberty, we're going to hear everything that's possible about it, an exchange of ideas, information, diagnosis, analysis, would that really seriously disrupt or disturb the present procedure that you have?

A I don't think so, because it already occurs. In cases where they need this information, then they obtain this information. Again, I'm not exactly sure I understand what you're saying, but if the Juvenile Court needs certain types of information in order to make a decision, for example, to take custody of the child, or something of this sort, then they have access to this information then.

Q But I'm talking about—okay, that's the thing I was assuming, because as you know, right now there is no court or judicial intervention in this process at all, or even anybody from outside of the system, that's what I meant, only in that context.

A Right. But in that case, I don't see, personally again, and I think I said it earlier, too, the necessity for judicial involvement with every case.

Q Okay.

[37]

A Because we hope our—one of our primary efforts is to build in protections for the children to prevent them from being abused by any system.

Q If I'm not mistaken, there are usually no psychiatric —separate psychiatric examinations or interviews conducted at the hospital of the patient prior to admission?

A No, not prior to admission, nothing than already has occurred . . .

Q Do you know, considering the in-depth working knowledge that you do have of the various mental health centers, whether there are any written policies in the mental health centers in regards to—written or unwritten policies, in regards to what should the—what the psychiatric examination should consist of? For example, like the length of the interview by the admitting physician, or the physician at the mental health center?

A I really don't know if they have any policies of this type.

Q Okay. How, for example, verification of information gathered from secondary sources? Do you know if they have any policy . . .

A I can't answer that.

NOTE: (Brief colloquy.)

Q Of if they have any policy in regards to the verification by the team—team members of information given by secondary sources or parents, teachers, and things like that?

A Do you mean . . .

Q Do they have a system . . .

A If the child's aunt says such and such happened . . .

Q You have to go to some other source to find out—or anything, [38] to check on the verification—to check on the correctness of the information?

A If you're saying whether or not the social worker's findings would be corroborated by findings of another person or something of this sort?

Q Or that what the social worker got from another person, the information he or she . . .

A Fits in . . .

Q Yeah, and would that be corroborated by anybody else, as a matter of policy? And it may very well happen, but as a matter of policy, is it required?

A I can't truthfully answer yes or no.

* * * * *

[40]

* * * * *

Q . . . sometimes it is family strife, or family stress, family problems that lead to the admission of a child—the request to admit a child?

A A disturbed child in the family can disrupt the family, or the child's problems may be brought about, possibly, by the family strife and so forth, so the point I think I was trying to make was, rarely, if ever, will you have a purely emotionally disturbed child in a family with no other problems there. So almost without exception, we're talking about family involvement in the child and adolescent program.

Q Could you see, then, that there is a possibility of potential conflict between the parent and child, if the parent is requesting admission to the hospital for the child?

A On occasions, possibly potential conflict, yes.

Q Never any conflict, though, between the parent and child—parents and child or guardian and child?

A Certainly. The—that may be part of the family strife situation. It has to be resolved.

* * * * *

[43]

* * * * *

Q Do you have any policies, written or otherwise, which began—like with the mental health people at the mental health center, which talk about how this admission procedure should take place? [44] For example . . .

A Where the parents would come with the child or so on and so forth?

Q . . . length of the interview, location of the interview, all of those things that I previously mentioned . . .

A No, because there is too much variation in this, if I'm understanding again, what you're asking, to say that an interview with a child should be fifteen minutes, or an hour and a half, or whatever.

Q Do you have . . .

A You can't lock it into this much specificity.

Q Certainly I understand that. I'm not trying to say that you have got this form, and you fill it out, and that's the only thing you do. Don't get me wrong.

A Right.

Q But are there policies as to what should be covered at the time—what subjects should be covered at the time—what subject matter, at the time of the admission?

A In the psychiatrist's interview with the child?

Q Yes, is there anything—any policy by the Southwestern Hospital itself in regards to that?

A Not to — not to indicate what the psychiatrist should interview the child . . .

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR WLADYSLAW P. MAZUR, taken on the 5th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
DAVID GOREN, ESQ.
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[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The witness was advised of his right to read and sign his deposition, and he specifically waived that right.)

WLADYSLAW PIOTR MAZUR, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A My name is Wladyslaw Piotr Mazur.

NOTE: (Brief colloquy.)

NOTE: (Defendant's Exhibits Numbers One through Five were marked for purposes of identification.)

Q You brought some documents with you and I've asked her to number them as exhibits, so what I'll ask you to do is identify each exhibit and then we'll discuss it. Would you identify Exhibit Number One?

A This is my curriculum vitae.

Q And is that current?

A That is the current curriculum vitae.

Q And you are a medical doctor, is that correct?

A That's right.

Q Are you also a psychiatrist?

A That's right.

Q Are you board certified?

[3]

A No, board eligible.

Q You are board eligible. And what is your present employment, Doctor?

A I am the superintendent of the West Central Georgia Regional Hospital at Columbus.

Q And how long have you been superintendent?

A Since September 3rd, 1974.

Q Is that when the hospital opened?

A The hospital opened, actually, three months later on December 2nd, 1974, when we first admitted our first adult patient.

Q When were the first children and adolescent patients admitted?

A In May, 1975. The unit was opened on May the 5th, 1975.

Q And what counties, or what area, does your hospital serve?

A Our area serves the west central Georgia, which consists of twenty-nine counties, which are conterminous with D.H.R. district four, which is composed of two catchment areas, area eighteen and nineteen, and district seven, which includes area twenty-five and twenty-six, serving counties—do you want me to name all the counties?

Q No.

A There are twenty-nine.

Q Twenty-nine counties. And are there community mental health clinics and programs within this area also?

A There are.

Q Could you tell me where those are located?

A There is one in Columbus, one in LaGrange, in Troup County; one in Carrollton in the same area, in Carroll County; in Newnan, which is Coweta County, then there is one in Griffin, Spaulding [4] County; in Covington, in

Newton County; one in Americus, in Sumter County, with a satellite in Crisp County, in Cordele; and these are the main full-time clinics. There are some satellite clinics which operate on a once a week or twice a month basis.

Q Through these community programs, are all twenty-nine counties in your area served with a community program?

A That's right. There are counties which do not have any facilities. But those counties contract with those that do.

Q What about children and adolescent community programs? Would that be in each of the main clinics that you . . .

A In each of the main clinics, they are served—children are served by the clinics. Now in some counties, like in Muscogee, which is Columbus, Georgia, there is a separate child guidance clinic which is separate from the mental—adult mental health, but the other clinics handle that—without separating the two.

Q What is the working relationship between the hospital and these community clinics?

A Well, the community clinics now, as of September—October, '75, belong to a consortium. Each consortium is conterminous with the hospital region service area, and the mental health and mental retardation program directors in each catchment area, and there are four catchment areas in my hospital district, these people, we refer to them as geographic unit directors, who are in charge of the community services, those four unit directors plus the district health directors and a superintendent of mental retardation facility, are members of this consortium,

[5] the full name—our full name is the West Central Georgia Mental Health and Mental Retardation Planning Consortium, shortly Consortium Six. The main mandate is to assign priorities to plan for budget and so on, so we are functionally acting in unison toward the common goal of providing a unified system—by unified meaning where the out-patient services and the in-patient services are acting in concert, rather than opposite ways.

Q Now would you explain the admission process to your hospital, with particular reference to children and adolescents?

A Well, first of all, there are two kinds of admissions. If it is a court ordered admission, there is no question about it . . . If it is a request from a family, or a recommendation from a school, then we evaluate the need for hospitalization. And of course, we have only less than twenty beds available, this process of screening is very, very thorough, because there is more demand than we can respond to in the way of providing in-patient treatment.

Q Are the evaluations performed right there at the hospital?

A Yes.

Q Do you ever refer an applicant to a community program for an evaluation?

A Well, some of them come via the local health—mental health clinic, but even then we still evaluate the need for actually having the patient on an in-patient basis. We prefer to find alternatives to hospitalization if possible, because of the shortage of beds, and because hospitalization is regarded as the last resort in treating a child. We prefer to treat the [6] child in the community,

preferably in its own family, unless the family is sicker than the patient.

Q Is there any policy, either formal or informal, that a non-emergency patient would be referred first to a community mental health clinic?

A Yes.

Q Is that written somewhere, or . . .

A I'll have to look into the—this book of policies and procedures. (Indicating Exhibit Three.)

NOTE: (Brief off the record.)

Q Would you identify Exhibit Number Two, first?

A This is a list by initial of patients who have been evaluated but not admitted.

Q Since when, Doctor?

A This is since—well, it would be since the unit was opened in May 5th, 1975, but the earliest date here is June, I think.

Q All right. Now, if you would identify Exhibit Three?

A Exhibit Three is the West Central Georgia Regional Hospital children and adolescent unit policies and procedures, which was written in September 25th, 1975, prior to the opening of the hospital for patients. And on page one we have the children and adolescent unit policy on referrals for evaluation.

Q And does that include a written policy that there will be a referral to the community mental health program?

A Yes, it does say here that a child or adolescent will be considered for admission by the clinical team of the

C&A unit in a screening evaluation session, which is to be scheduled by the unit's social worker. Where feasible the community worker referring the [7] patient is requested to attend the screening evaluation session in person with the patient, and where feasible, with the patient's parents or guardians. The community worker making the referral is requested to bring or send written information including any of the following available material: A psychological (sic) history, a developmental history and immunization record, a psychological evaluation, a psychiatric evaluation, a summary of previous treatment—of previous treatment approaches, recommendations for treatment at time of admission, and any proposals regarding plans after discharge.

Q You mean even before admission is made, there is a suggested plan for discharge?

A Oh, yes, this is the most important—this is the most important part of treatment, what are we going to do with the child after—after discharge, the hospitalization being regarded only as a last resort emergency measure which we try to keep as short as possible.

Q In the first paragraph here there is a distinction made between emergency admissions and other admissions?

A That refers to the, I think, to the court ordered emergency, or the non-emergency commitment. There are two kinds . . .

Q Are there any kinds of emergency voluntary admissions that you can think of?

A Well, yes, if the child is very disturbed and is suicidal or homicidal—there are homicidal children, so

that would be considered as an emergency. Wherever there is a life-threatening behavior, be it directed towards the child himself or herself, [8] or others, or things like fire setting, this kind of thing is always considered an emergency which warrants in-patient treatment.

Q Now in the non-emergency voluntary admissions, what kind of standards or criteria would be used in deciding to hospitalize the child?

A The main point is to find out how disturbing is the child's behavior to the family, the environment, and how dangerous is it. If none of these factors exist, then we try to treat the patient on an out-patient basis if possible.

Q Do you have any policies regarding treatment of the family at the same time the child is being treated?

A Yes. This is the basis of the approach, because wherever there is a sick child, there is usually a sick family.

Q Do you have any idea in what percentage of the cases the parents are treated along with the child?

A Oh, I couldn't give you off-hand any statistical data, but there is always an attempt to involve them very closely in the treatment plan and post discharge plans, because without their cooperation, whatever we do is useless.

Q Are you familiar with any cases in which the parents refused to have . . . treatment?

A Yes, we had a case where we felt the child was not the sickest member of the family. That was that the patient was previously hospitalized in the Central State Hospital, and through evaluation of the family backgrounds, we determined that the—it was actually the

mother who was the sicker—the sickest member [9] of the family, and they refused to—even to give us permission to obtain her records—her psychiatric records. This is the case that you're familiar with.

Q What action did you take in that case?

A We have asked for temporary custody in cooperation with the Children's Protective Service in Columbus, who were the initiators of the custody proceedings. We helped them to organize this case so that they could get the custody of the child.

Q Since the hospital has been open, is this the only specific case that you are familiar with?

A That is the only specific case that I'm familiar with.

Q How many children have been admitted to the C&A unit, do you know roughly?

A I'm sorry, I cannot give you that.

Q Will this be shown in . . .

A It will be shown in Exhibit Four and Exhibit—the one that gives the—this one.

Q Exhibit Four, is that what you're . . .

A No, Exhibit Four includes patients who are . . .

Q Does Exhibit Four include both your current patients and those that have been discharged?

A And discharged, yes.

Q Does Exhibit Three also describe the program . . .

A Yes.

Q . . . of the C&A unit in your hospital?

A Exhibit for admission—admission procedures, routine admission orders, medicine hours, standing orders, medical procedures, emergency screening procedures for evenings and weekends, [10] information on the children

and adolescents which deals with things like individual treatment, telephone calls, home visits, letter writing, passes and so on, the patient rules and regulations, the policy on patient rules and regulations of the childrens unit, privileges, restrictions and behavior modification, description of various levels of privileges that the patients may have, those which separates the patients that need to be under very close observation, from patients who, after repeated observation and orientation and treatment, may have gained much in self control . . . allowed privileges which encompass more responsibility, like going from the campus unattended. And then the highest level is a child with—that has additional privileges and responsibilities. This is in case when the condition for which they have been admitted has clearly improved. They may go to the stores and take bike rides on the campus. We do have donated bikes from the community. They may sign out for an unescorted walk, have weekends or longer than twenty-four hour passes, may go the snack bar unattended, and so on.

Q Do you have any idea of the average length of stay for children on your unit since it was opened?

A The average length of stay is of course, longer than the adult population. Now the adults average about twenty-four days. Now the children, it would be—I'm sorry, I don't have a computer to work with, but it is possibly even twice as long.

Q Can you think of any reason why it would be longer?

A Well, because when hospitalization of a child takes place, this is usually a much more serious situation than the adult popu-[11]lation. To remove a child from its home environment is a much more serious step than to remove an adult.

Q Okay. Doctor, do you have any periodic review at your hospital?

A Yes, I brought—brought the utilization review plan, the objective of which is the maintenance of high quality patient care and an increase in the effective utilization of hospital services.

Q Who conducts that review?

A The clinical director does.

Q Would there also be periodic reviews by the staff of the children and adolescent unit?

A Oh, yes, we do have a consultant—outside consultant who is not a member of the staff, Doctor Rains, who has practiced child psychiatry in the community of Columbus for a number of years, was a member of the staff of the Bradley Center and is now in full-time private practice in child psychiatry, and we have fairly recently—it was not from the beginning of the operation, but after about two months—we have retained his services as our consultant, and he comes once a week and reviews the cases.

Q Would he review every case each week?

A That would depend. Sometimes a review of a single case may take his entire visit, because they present to him the most problematic cases. We, of course, have our own staff who can handle the more routine matters, a pediatrician who is very well versed in the problems of—emotional problems of children and retardation and also drug abuse.

[12]

Q A pediatrician is the head of your C&A unit?

A No, the actual unit director is—is not a pediatrician. We have non-medical directors.

Q But the chief position is a pediatrician?

A Yes.

Q And there are twenty beds for children and adolescents?

A The unit was built as a forty bed unit, but the present austerity measures secondary to the budgetary crisis all over the world and in the United States and Georgia, permit us only to operate half of that.

Q Are you familiar with how often there would be staffings on each case? Weekly or monthly?

A There is a staff meeting every day.

Q Every day. Do you know if Doctor Rains reviews cases after they've been there for a certain length of time, say once a child has been there for, say, thirty days, Doctor Rains would begin to review their cases?

A I would think that . . . he may be called on the phone for consultation just at the time he evaluates the patients. There is no rule of thumb to that. We play it by ear, to utilize his services as effectively and efficiently as possible.

Q Are you familiar with any particular problems other than the one we discussed about the parents who do not participate in treatment? Are you familiar with any other parents who are reluctant to take their children back home when your staff recommends it is time for discharge?

A Not to my knowledge, no.

[13]

Q Okay.

NOTE: (Defendant's Exhibit Number Six was marked for purposes of identification.)

Q Exhibit Five is the utilization review policy, is that correct?

A Yes.

Q Now Doctor, if you would identify Exhibit Six, please?

A These are the legal papers which accompany each admission, be it voluntary or involuntary, the physical examination, the history and mental and physical examination. There is one that's a form and one that is written, and we have a social history too.

Q Is that for each patient that's currently on the C&A unit?

A Yes. And some of them include psychological consultations prior to admission, an interview . . . accomodations by psychologists and so on. The names are marked out on the usual places, but I can't guarantee that they have not—occur . . . in the text it should be.

NOTE: (Brief colloquy.)

Q Doctor, one of the primary contentions in this case is that there is a necessity for judicial proceedings prior to the voluntary admission of each child to a regional hospital. In your opinion, as superintendent of Columbus, do you think that it's necessary to have a judicial proceeding prior to every admission to screen cases?

A No.

Q And why not, Doctor?

A I don't think it's necessary, period. To require such is a reflection on the honesty and good will, competence of the [14] medical staff.

Q Do you feel that the current hospital procedures are adequate in screening cases?

A Oh, yes. There are more children that we turn out than we take in, because of the shortage of beds, for one thing.

Q That's all the questions I have.

EXAMINATION BY MR. GREENBERG:

Q Doctor, let me just preface all of these questions to say that when I refer to admissions, most of the time I'll be referring to voluntary admissions pursuant to the statute which is the subject matter of this whole litigation which provides that parents or guardians can admit children under the age of eighteen, so if you have any confusion or any questions about what I'm referring to when I talk about admissions, please let me know, because I don't want . . .

A You mean the voluntary admissions.

Q Yeah, most of the time when I say admissions I going to mean voluntary admissions . . .

A Not commitments by the Juvenile Court or anything like that.

Q Unless I specifically say it, and if you don't quite understand the questions, please let me know.

A Sure.

Q Let me just ask you very briefly, what is the present number of children in the children and adolescent unit?

A They are full, twenty.

Q Twenty. And how many of them are there pursuant to the voluntary admission statute, do you know?

[15]

A I'm sorry, I was not prepared to answer these kinds of detailed questions. It can be—it can be culled from this, because you have admissions here listed, number seventeen is voluntary admissions by parents or guardians, and most of them are seventeens, so . . .

Q Fine. Okay, that was my fault, that was my misinterpretation of this. I just assumed that first sheet of the Exhibit was all the people who were discharged. I apologize. Are the children and adolescents units separated? Is there some kind of dividing line between children and adolescents?

A No. Actually, we have—the majority are in the age group of twelve, I would say. The oldest child is sixteen, but there are but a few of them.

Q And they all reside in the same facility?

A They all reside in the same facility.

Q Are any of the . . .

A But it is a completely separate building from the adults.

Q There are no patients under eighteen who are in the adult facilities or wards?

A No. There might be occasionally.

Q Okay. I said—let me narrow that down. Then there are no patients under eighteen who are admitted pursuant to the voluntary admission statute in adult wards?

A Again that would be very difficult for me to answer that. When there is an individual who is just under eighteen, and who is requesting a voluntary admission, and we, of course, do not have enough space to hospitalize an eighteen year old, he's practically an adult size-wise and behavior-wise, with the [16] children, he might be admitted to an adult ward.

Q Is it possible, then, that there are some people who are less than eighteen years old, and voluntarily admitted pursuant to this statute that we're concerned about here . . .

A It could happen.

Q . . . they might be in the adult wards?

A In case of overflow, there is an urgent need to admit the child, we might transfer our oldest patient from the children's unit to sleep on an adult ward. We have just initiated this contingency plan, because when we reach the maximum bed occupancy. I don't think it has been implemented so far.

Q You say that—you've said that referrals come often from community mental health centers, is that right?

A That's right.

Q You also have people come directly to the hospital for purposes of admitting their children?

A Very few in the case of children. It's more adults.

Q Okay, so most of them come—are referred to you from the county centers.

A That's right.

Q If you could, just for purposes of clarification, could you just describe what would happen, let's say, in a typical situation where the parent wanted to admit his child pursuant to this statute, who lived, let's say, in one of the outlying counties that had a community mental health center?

A I can only speak in hypothetical situations.

Q Well, hypothetical—I mean, what would they do if they [17] wanted to admit the child and how would they go about doing it?

A They would have to bring the child to the mental health center and have mental health professionals review

the situation. By mental health professionals I mean a social worker or a psychologist, usually, who would then conduct a sort of pre-screening interview and assess the situation and determine whether the hospitalization is necessary. Then refer them to us. Where again, a screening process would take place.

Q So for sure if someone came to the hospital, to you directly—I realize that Ms. Kirkley went over some of this with you originally—if somebody came directly to the hospital to admit their child, would they be referred to the community mental health center? Is there any possibility that they might be—in a non-emergency situation, is there any possibility that the child . . .

A In a non-emergency situation, certainly they would be—they would be referred someplace else.

Q Okay. So the parent who has a child they would like to admit to the hospital would go to the community mental health center, and that child would then be seen by members of that staff. Do you know, for example in the community mental health centers, how many people they have—professional staff; psychiatrists, doctors, psychologists, social workers?

A None of the clinics in our hospital region of twenty-nine counties does have a full-time psychiatrist.

* * * * *

[19]

* * * * *

Q Okay. So let's just take our hypothetical where we are, then, let's say in one of the counties the parents come to the community mental health services there and say they want to admit the child. Let's just say they come in on Wednesday, March the 1st, or something like that. Then what would happen at that time, would an interview be set up for them to see anybody . . .

A If they bring the child with them, yes, somebody would interview the child as well as the parents.

Q At that time?

A At that time.

Q And then what would the next step be?

A The next step would be depending on the urgency of the situation.

Q Okay, let's say a non-emergency situation.

A In a non-emergency situation they would want to get some information from the school, if there has been—there have been any scrapes with the law, they would like to have some [20] information from the Sheriff's Office or some children—come into conflict with the law for drug possession and so on, so we want to get all the information collected then.

Q And—I don't know if I made the question clear enough. At the initial interview, would that be done by the social worker?

A Probably the social worker. It could be a psychologist, could be a nurse.

Q Okay, but it would be somebody at the facility?

A In the mental health profession, yes.

Q So you would have—you would have the initial interview and then there would be a search for secondary—information from secondary sources other than the child and the parents which brought in the child.

A The physician—the family physician could be a very important source of information.

Q So after . . .

A The pediatrician if they have one.

Q So after all this information was collected, what would happen then?

A That is presented to our adolescent unit.

Q Okay.

A Either by letter or phone, and then they schedule the evaluating interview at Columbus.

Q They would have the evaluating interview at Columbus?

A If the recommendation is to—for in-patient treatment.

Q And who would that recommendation be made by?

A By some professional in a referring agency.

Q And that professional could be a part-time psychiatrist or a [21] psychologist or the social worker?

A Could be, yes, yes.

Q So one of those people in the facility, in our case, makes a recommendation based on the interview with the child and information that was gathered from other sources?

A One agency is the Family and Children's Service.

Q They would go to them for information also?

A Yes.

Q And based on the interview and the information gathered from all of these secondary sources that you discussed, they say, well, we think the child should be institutionalized . . .

A Right.

Q Then they would contact the children and adolescent unit at your hospital . . .

A Yes.

Q . . . then an appointment or admitting—evaluation—I don't know if you used the term for interview, evaluation, a time would be set up . . .

A An intake interview or something.

Q And that would be conducted by somebody from your hospital . . .

A That's right.

Q . . . would go out to the . . .

A No, no, they would have to come to Columbus.

Q Okay. So this evaluation—it would be a recommendation that would be made at the community mental health center?

A That's right.

Q And to act on that recommendation, the involved parties would [22] have to go to the hospital . . .

A Of course, making a trip to Columbus and entering the grounds of the hospital does not constitute admission.

Q No, no, of course not. Of course not. So where we are now, we're at the gates of the hospital. We're not admitted, but we're at the gates. And who would come from the county, the community mental health center, would it be the . . .

A We request, when possible, the professional from the referring agency to be there. This is not possible in all cases. We, of course, accept written reports, recommendations, and so on.

Q Okay. So you have—there could be any number of situations, then, by the time the child is brought to the hospital?

A Yes.

Q The child would be there, right? The child would be brought to the hospital for purposes of determining . . .

A Usually, yes, unless the child is in some other institution.

Q Okay. Well, let's say the typical—in our hypothetical—is the child is in school, no other institution. Is it possible, then, that the admitting physician at your facility could make a decision after he has been informed of the case from the community mental health center, been told of that professional staff person's recommendation, has had sent to him the various items, you know, reports, copies of materials, school records, etcetera, has had those things sent to him, and then he will make—is it possible he will make a decision based on his phone contacts or letter contacts and the papers, without interviewing the child?

A No, not without interviewing the child. A tentative—tentative [23] agreement would take place, on the basis of the pre-admission information.

Q I see. So actually, there's like three—there could be three steps in this, like the recommendation, or the decision at the community mental health center, the recommendation on the admitting physician's basic feeling that there is grounds to have this child admitted—the pre-admission decision, and then finally, before the child is actually admitted, though, he would have separate interviews . . .

A Interview with the admitting physician.

Q And would the admitting physician speak personally to anyone else?

A Yes.

Q Who would that be?

A Whoever brings the patient; father, mother, guardian.

Q Is it the usual situation when the referral comes through the community mental health center, that the child is brought there by somebody from the community mental health center?

A No, it's usually the parents who bring the child.

Q Okay. And so . . .

A Those centers are under-staffed. They can't afford to send professionals to accompany the children.

Q Is that—is it possible that that under-staffing—I would assume, then, in light of your obvious efforts to make sure that no child is institutionalized incorrectly, and in light of what—the burden of their—really overburdened by their number of cases, and perhaps their under-staffing, lack [24] of people there, that the thoroughness required in getting all this information takes some time, and there are no hasty decisions made to admit a child?

A No. No.

Q Do you have any—I realize—if you can't answer this it's all right, but do you have any idea of the time that would elapse from, let's say, the day the parents would take the child into the community mental health

center for purposes of admitting him—voluntarily admitting him, and the time that the actual decision to admit is made by the admitting physician at your hospital?

A The unit director of the childrens unit would be better qualified to answer this question, but I would say that it may vary from the same day if it is—again, if it is an emergency, but we are not talking about emergencies . . .

Q No, just non-emergencies.

A Oh, it may take a week. It may take a week, by the time you get all the information pulled together. Depending also on beds. We may have no beds available, so . . . There is no hurry. They can assemble as much information as they can during this period of time.

Q Then it would be fair to say that the hospital, in a non-emergency situation, is in no great haste to put somebody in there?

A No, no, no.

Q Okay. I think I understand how it works on a dav to day basis.

A There is no motive to have them in.

Q No, I understand that.

[25]

A In fact, if there may be any dissatisfaction on the part of the community is that we do not have enough beds to give children, and in fact, our childrens unit was activated at the price of phasing out a medical-surgical unit, which had to be eliminated because the (intelligible).

Q When you were there prior to the institution of the

children and adolescent unit, where did children who would be voluntarily admitted under the statute—where would they go?

A No other place except Central State Hospital.

Q Would you make the decision at your facility, or would you just refer them to Central State?

A We simply didn't have any crises.

Q Okay.

A People didn't know that the hospital exists, and they were told that we do not have a children's unit.

Q It sounds like your hospital has a pretty close working relationship, out of necessity, with the community mental health centers, is that basically true?

A Yes.

Q Do you know if there . . .

A In fact, we share staff. Like I'm seeing patients . . .

Q That's right.

A . . . in the out-patient clinic.

Q Are there any policies set out—I know there are certainly admission policies which are in your Exhibits, but are there any policies, set out by the hospital, yourself, or the clinical director, in regards to the conduct at admissions at the mental health unit? Or do they have any policies as to what standards [26] and procedures they should follow? I can see you're not quite sure what I mean. Do they have any policies in regard to who should initially interview the child, the length of that interview, the subjects that should be covered, where that interview should take place, what secondary sources should be used,

if there should be any verification of information they get from secondary sources, things like that?

A I would say that they have such guidelines.

Q And are those guidlines written anywhere?

A I wouldn't be able to answer this with . . .

Q They aren't drawn up by you?

A No. No.

Q Okay. And . . .

A Up till now—up till now they really have been a separate systems in which the hospital has not had any input, but from the time of the consortium was created, there would be a closer relationship, in that the—each region—the superintendent of a regional hospital is also a chairman of the Mental Health and Mental Retardation Planning Consortium.

* * * * *

[28]

* * * * *

Q Just looking at, I guess it is Exhibit Two, which is a list of patients who have been evaluated and not admitted, and the patients who have been admitted, I notice that there are some referrals from the Department of Family and Children Services as well as the community mental health center. Is it the policy—do you know if it's the policy of the community mental—of D.F.C.S. first of all to refer cases to the community mental health center?

A This is the beaten pathway, because before the hospital was in [29] existence that's what they would do.

Q Okay, let me just ask you then, maybe to make it clear, on some of these where they are referred—I'm not concerned basically about any of this over here, but just

on the referrals, does this mean that these children who were referred to the hospital did not first of all go through the—like go through the community mental health center? Like on this one?

A That's possible, yes. But I think it really would be useful to have the people from the units to have answered these questions.

Q I understand. I don't expect you to be omniscient, you know. It is possible, though, according to Exhibit Three, that somebody could be referred from D.F.C.S. and not go through the intermediate step of being referred to the community mental health center?

A As a hypothetical question, I would say yes, because they may have already a very—very thoroughly researched background of the patient which had included prior contact with the clinic, and so on.

Q Okay.

NOTE: (Brief off the record.)

Q It would seem to me—I would assume, looking at the people—children who were admitted, that the standard diagnosis criteria is the D.S.M.-2?

A Yes.

Q And do you know generally—not just what's on the Exhibit Four, but just generally from the history of the children and adolescent unit, the number or percentage of children admitted pursuant to the voluntary admission statute with an initial diagnosis of perhaps one of the transient situational disturbances?

[30]

A Adjustment reaction of childhood?

Q Yes, something like that.

A Yes.

Q Do you know what percentage that would be of the . . .

A I am unable to answer that question.

Q Okay.

A We have not been operating that long to have any valid statistical data.

Q Okay. I guess for purposes, since we've been using the word emergency and non-emergency situation, I should get that straightened out, that when you talk about—what you said in your direct examination, that an emergency situation would be something that consisted of life threatening behavior?

A Yes.

Q And then a non-emergency situation is—generally—I don't want to put words in your mouth.

A Problems. Problems in getting along, learning—problems in learning and so on. This is the kind of problems that are referred to a psychiatrist.

Q And the decision to admit or not is based on the degree of disturbance or dangerous behavior to the family and the child's environment?

A Yes.

Q Okay. Based on that type of—what you've already testified to, is it fair to say that it could be that the interests of the child in this admission procedure, may be at odds with the interests of the parents?

A Interests of a child at odds with the interests of the parents?

[31]

Q Well . . .

A It may be at odds with the wishes of the parents as expressed by them at a given time, like in this case that I have mentioned.

Q Okay. Let me just ask you, in the one case you mentioned where the parents refused—for example where the parents refused to join treatment, you said the patient had previously been hospitalized in Central State?

A (Nods in the affirmative.)

Q I think you said that the unit basically felt, that after evaluation, that the mother was the more sick person of the family. Do you know if that patient was hospitalized at Central State under a voluntary admission? Do you know why that child was in Central State, I guess that's what I'm asking.

A I am not—I do not recall—the patient spent quite some time. I think that they, in Central State, the delay—the delay in the discharge, was due to the fact that the parents were not too keen to have the child back in the home.

Q But you don't know why the child was initially at Central State?

A I do not recall that.

Q But you did not admit the child . . .

A No

Q . . . to your institution? And I guess the child had gotten out of Central State because the parents had agreed to take it back—take her or him back?

A Yes.

[32]

Q Would you agree generally, that in the admission system, that it's important to get as much information as possible before the decision is made to to admit the child?

[32]

A Unqualified, yes.

Q And would you agree that the more facts available to the—I guess this is a corollary to the first assumption—that the more facts available to the physician the better he'll be able to make a reasonable diagnosis and . . .

A We do not operate a boardinghouse, where for a sum of money, somebody can get room, board and supervision.

Q Okay. How would you say the burden is on your physicians at the hospital? Do they have a heavy case load?

A Well, that depends on the point of view. There are hospitals that are much better staffed, private institutions, and there are hospitals that do not have half of the staff that we have.

Q I mean in regards to the, say—do the people that are involved with the children—the physicians who are involved with the children and adolescents, both in admitting and in treating, subsequent treatment of the children, do they also have to handle other type cases?

A The pediatrician also does provide medical coverage for the mental retardation unit.

Q What about the psychiatrist?

A The psychiatrist has other duties as well.

Q I'm sorry, could you repeat that?

A Has other duties as well.

Q So he—he or she, is handling both cases in the child and adolescent unit as well as some, perhaps, adult units.

A We would like to have a full-time psychiatrist—full-time child psychiatrist, of course.

Q Well, I mean—I'm not talking about just the characterization [33] of his ability, but I mean is the psychiatrist—who he cares for—so you have psychiatrists who are working with the children, but they are also having to work with the adults . . .

A Yes.

Q . . . because of time, money . . .

A That's right.

Q . . . limitations?

A That's right. But there is also a psychologist who spends most of his time there.

Q "There" is the hospital?

A The clinic—the child and adolescent unit.

Q Okay. So assuming then, there is a fair to heavy burden on your staff in the admission and treatment of children and other patients—would that be a fair assumption?

A That again, depends on the point of view that you look at this.

Q Okay. I won't try to make an assumption, then.

A If you think of ideal conditions, of course, it's different than when you think in terms of what is adequate, that's a different point of view. I would say we have adequate coverage.

Q Okay. Assuming that the more facts available to your staff and to the community mental health people, which I do believe you said are pretty over-burdened?

A Yes.

Q Assuming the more facts available to them the better—the better the treatment and the standards for admission, and assuming also that—like I said before, obvious in your Exhibits and in your testimony—the care in which facts are sought and the care in which you take to make sure that children [34] are not voluntarily—should say are not committed without . . .

A Good reason.

Q . . . then wouldn't a procedure which would consolidate some of the various steps taking place at different times and in different places presently, would such a procedure that would facilitate the gathering of all pertinent facts be helpful to the admitting physician at your hospital?

A I do not quite understand your question, what you mean by that.

Q Let me go over it then. You have gathered facts, both at the hospital—some at the hospital level by your use of psychiatric evaluations and interviews, of both, I imagine, parents, guardians and children—you also have gathered facts in the counties by apparently . . . D.F.C.S., and the gathering of those facts—those facts are gathered at different times and presented to the admitting physician at a subsequent time. What I'm trying to say, if there was a procedure which would facilitate the gathering of facts, help the overworked community mental health people in the gathering of facts, and allow an

opportunity for all the people who were involved in gathering those facts, to get together for the purpose of exchanging the information gathered, wouldn't that type of procedure be helpful in determining whether a child should be admitted to the hospital or not?

A What procedure do you mean exactly?

Q Well, it could be, let's say, all of these people getting together, and some person—not necessarily a Judge, because I don't want to engender some type of image, but an independent [35] person who would perhaps be able to be helpful in coalescing all that information together; all of this information being brought before a group and perhaps somebody there, an independent arbitrator, an arbiter there, to listen to this information and help consolidate that information gathered.

A You mean to duplicate—duplicate what we are doing?

Q No, no, not to duplicate it, but to make sure that all the information gathered is being done—just like your physicians' expertise are in psychiatry, no doubt about that, and the D.F.C.S. people, their information and the mental health people have certain expertise, but the idea is to get—to make sure that information which is gathered is utilized, and not wasted. That would be a goal . . .

A To make sure that the information is not wasted?

Q Well, certain people may have information that may be gathered by one source or another, may not be made known completely because of the way it's presented, or in the manner in which it's done. I mean, that does happen.

A I don't understand how could that happen. If you do get a report, . . . certainly read by the people who screen for admission.

Q Okay. But sometimes those reports, the way they're done, can sometimes be less than overall illuminating, isn't that true?

A Oh, I would consider all of them to be done in the problem oriented fashion, which facilitates the retrieval of information—of particular items of information that you are looking for at a given time. Might save some time, instead of reading the reports through to find a particular item of information [36] if you have a problem oriented system you can do it in a shorter time. But it's a matter of technique rather than a separate system of screening.

Q Okay. Then you don't feel that it would be helpful for all of the people who are involved in the decision—to get information and present it and—who are involved in the decision to admit, to get together at a particular time and . . .

A Well, I'll put it in this way, I don't think it would be helpful for someone else to do this job for us. I would certainly welcome to have more people on my staff, a child psychiatrist, a group of psychologists, social workers who could spend more time and more detail with all that, but a separate, duplicate system of screening, I don't think it would be necessary or good.

Q Okay. Well, we're both missing . . . each others assumptions. I'm not talking about duplicated procedures, but I guess that's a term of art that we both have relative definitions of that term, so let's just . . . . Do you feel that any type of other unit of getting together of all of the people who have information would be a duplication of procedure . . .

A Well, we do that. We do that, because we do invite social workers from the centers . . .

Q But they do not always come at the time . . .

A They do not always come. That's not always possible.

* * * * *

[42]

Q Okay, and the consultant comes once a week?

A In addition to that, yes.

Q And what would be the general purpose of those meetings?

A To get his opinion, a second opinion, an independent opinion of a person who is not an employee of the hospital, as to what we are doing.

Q And his opinion in regards to treatment, diagnoses, change in diagnoses, perhaps—whether a change of treatment should be—there should be a change in treatment or things like that, things of that nature?

A Well, a consultant—consultant's opinion is never a direct order.

Q Oh, sure.

A But certainly it is not—not countermanded usually. It's usually followed.

Q Okay. Then you mentioned that your own staff would handle the more routine matters. Could you just kind of explain what the more routine matters would be?

A I wouldn't say that they were routine. If there is—if among the staff, several—we have a team approach. If there is a difference of opinion between staff members as to the diagnosis or treatment, then of course, we need to have an umpire, and the evaluation of the input given by the consultant—an impartial consultant, helps to tip the

scales of opinion. And of course, by diagnosis I mean not a diagnostic label, which most people understand. Diagnosis in Greek means thorough understanding, and thorough understanding is certainly never a diagnostic label which can be put into two or three words, which [43] is a means of shorthand information—communication between professionals.

* * * * *

[47]

* * * * *

Q Okay. But just from the expression of your concern about—you do have some view points about the efficacy of the—of a legal system in regards to admissions, meaning you felt—I think you said you felt that the idea of a court getting involved in admissions was basically a reflection on the good will and trust and competency of your staff and I would assume that that's somewhat less than a recommendation for the use of the legal system or judicial system?

A I do not—I personally do not see the need because, as a physician, the guiding light for me is the Hippocratic oath, and in that—that encompasses the conduct.

Q Might it be helpful if the review team that you have, or your staff, including your child psychiatrist, if it contained someone who would basically represent the child's legal interest?

A Oh, yes, we have that. In our hospital we have instituted what is called Patient Advocacy Committee, which is not to replace, but is to supplement the function of the Patient Advocacy Unit, which is at the State level in Atlanta. And a member of the Patient Advocacy Unit is—one of the members is a lawyer from the Legal Aid Society.

Q Oh, that's Dan?

A Hay.

Q Hay.

A And he attends the monthly meetings of this committee and if [48] there is any question that the patients' rights may have been violated, this is investigated by this committee.

NOTE: (Brief colloquy.)

Q Are you pleased with the system as it works now?

A Yes.

Q Okay. Would you say it would have value to be instituted on a state-wide level?

A The Patient Advocacy?

Q Yes.

A Oh, I would think so. I would think so.

Q It hasn't caused any disruption, or problems with your review?

A No. No, it gives me, as the superintendent, another way of assuring that the patients' rights are not violated, and this committee is not—its main purpose is to put under a magnifying glass, any complaints that the patients have. The mandate for them is not to be objective, the mandate for them is to put it under a magnifying glass, in fact to be biased in favor of the patient.

Q And you see that as being—ultimately having good . . .

A Yes, because the inclination that I get there is complete, and there is no stone left unturned to indicate that something improper may have happened to the patient.

Q Now you don't consider that to intervene or to serve as a reflection on the competency of your staff?

A Oh, no.

Q Then would there be . . .

A It's a tool to improve procedures and policies.

* * * * *

[50]

* * * * *

Q Maybe I should put it this way. You said the average length of stay for adults about twenty-four days, and then Ms. Kirkley asked you what the average length of stay for a child was you said you honestly didn't quite know.

A We do have one, two, three children who were admitted in June.

Q Well, I'm talking about just averages. I'm not trying to pin you down on this, I'm just saying the average length of stay may be—may be twice as much as an adult?

A Yes. Oh, yes.

Q Okay. Then when Ms. Kirkley asked you why that was, you said the hospitalization of a child was much more serious a matter than that of an adult, is that right?

A Well, we—an adult can himself come and say I'm very sick, or I'm thinking of killing myself, or something like that.

[51]

Q Okay. When you're talking about adults are you talking about both voluntary and involuntary situations, or just voluntary situations?

A Both. Both.

Q But you realize that for an adult there is a court proceeding before he can be—there is a proceeding—court proceeding?

A Yes.

Q Okay. The last I have to ask you is, in your experience as a psychiatrist and based on studies you've done and your writings, would you say that hospitalization of any type can create obstacles for patients returning to the community?

A It can, yes, mainly to the stigma that still lingers among the population.

Q And there is a stigma attached to the . . .

A Unfortunately—it's unfortunate, but true.

Q And this stigma is—for psychiatric hospitalization is more severe than hospitalization for organic or physical . . .

A When people go to have their appendix out, they publish it on the radio, local radio, they have it printed in the newspaper, and yet they go to a psychiatric hospital, they don't do that, and in fact . . . it did happen, although there should not be any difference between the two.

Q But there does exist a difference . . .

A It does exist. It is the legacy of the past.

Q Which prevails in the present?

A Oh, yes. It still lingers. And of course, the more sophisticated, the more educated the population, the less this is evident.

Q I have no further question.

* * * * *

EXHIBIT 3

WEST CENTRAL GEORGIA REGIONAL HOSPITAL
CHILDREN & ADOLESCENTS UNIT
POLICIES AND PROCEDURES
SEPTEMBER 25, 1975

[1]

C & A UNIT POLICY ON REFERRALS FOR EVALUATION

Hospitalization for a child or adolescent will be considered only when it is therapeutically necessary or preferable over community outpatient care.

All referrals should be made through the local community mental health clinic or county public health department with a community-administered psychological evaluation recommending hospitalization. A child or adolescent will otherwise not be considered for admission unless in a case of emergency or where there is specific therapeutic justification for inpatient care.

A child or adolescent will be considered for admission by the Clinical Team of the C & A Unit in a screening-evaluation session which is to be scheduled by the Unit Social Worker. Where feasible the community worker referring the patient is requested to attend the screening-evaluation session with the patient; and where feasible, with the patient's parent(s)/guardian(s).

The community worker making the referral is requested to bring or send written information including any of the following available material: a psychosocial history, a developmental history and immunization record, a psychological evaluation, a psychiatric evaluation, a summary of previous treatment approaches, recommendations for treatment at time of admission, and any proposals regarding plans after discharge.

The decision on admission in the screening-evaluation session is based on the following criteria: The clinical assessment of the patient, treatment available by community resources, treatment offered in the C & A Regional

Hospital, and special mitigating circumstances indicating either inpatient or outpatient treatment.

When the screening-evaluation session results in a decision against admission to the C & A Unit the Clinical Team will recommend alternative community resources and make a referral to an appropriate agency. The C & A Unit Social Worker will inform the community agency of the referral and request follow-up.

[2]

CRITERIA FOR ADMISSION TO THE C & A UNIT

Patients with Intelligency Quotients or Social Quotients over 70 and who are less than 16 years, 6 months of age may be admitted to the C & A Unit.

An exception to this will be children under 16 years, 6 months of age and with Intelligence Quotients of Social Quotients below 70 who may be admitted to the Children & Adolescents Unit for evaluation and diagnostic tests, subject to prior approval from the office of the Superintendent.

[3]

WEST CENTRAL GEORGIA REGIONAL HOSPITAL
CHILDREN AND ADOLESCENTS UNIT
ADMISSION PROCEDURES

PURPOSE: To provide guidelines for the rapid and orderly processing of patients into the Children and Adolescents Unit.

1. Evaluation—A child or adolescent will be considered for admission by the Clinical Team of the C & A Unit in a screening-evaluation session which is to be scheduled by the Unit Social Worker. Where feasible the community worker referring the patient is requested to attend the screening-evaluation session with the patient; and where feasible, with the patient's parent(s)/guardian(s).

2. Physical & Mental Status Examination—Arrangements are made for a time when a physical and mental status examination can be performed by the physician. This is done on the Children & Adolescents Unit. At this time, the physician makes final preassessment and writes the order for admission.

3. Admissions Suite—The patient is then sent to the Admissions Suite, Medical-Surgical Building, with his or her parents or guardian for completion of necessary paperwork and photograph, lab work, and x-rays. At this time, his personal belongings are checked and list is made. Inappropriate items are sent home with the family.

/s/E. T. ZEITOUNI, M.D.
E. T. Zeitouni, M.D.
Acting Clinical Director

[8]

WEST CENTRAL GEORGIA REGIONAL HOSPITAL
CHILDREN AND ADOLESCENTS UNIT
EMERGENCY SCREENING PROCEDURES
(Evenings and Week-ends)

PURPOSE: To establish guidelines for admissions to the unit during evenings and weekends.

I. Procedure for handling calls requesting Emergency Services/placement:

A. Complete Emergency Screening forms, (located in the nursing station). Staff nurse on C & A will handle this.

B. Determine if child has been referred by a Mental Health Center, psychologist, or psychiatrist. If not, refer the caller to the Mental Health Center serving that geographic area (see attached list). If the referral is appropriate (child referred by Mental Health Center, etc.) be sure to complete all questions on the Emergency Screening Request Form.

C. After completing all items on the form, tell the person calling that the Social Worker will call and schedule an appointment the following morning for evaluation. This is only if the call is received Sunday to Thursday evenings. If the call is between Friday evening and Sunday noon, the person contacting WCGRH will be notified Monday morning by the Social Worker to schedule appointment.

D. If the contact person requests services more immediate than those provided above, supply the caller with the available and appropriate community referral service number.

E. Follow Up: Staff taking call and giving referral service numbers to contact should follow up with call to referral service.

F. All contact sheets (whether referred or appropriate contacts) are to be placed in Social Worker's office as soon as completed.

The Social Worker will make return call to contact the Mental Health Center or psychiatrist by 9:00 a.m. the following morning. An appointment will be scheduled as soon as possible.

[9]

Mental Health Center Emergency Referrals over Weekend:

If a Mental Health Center makes an emergency referral over the weekend when screening team members are not available:

A. Nurse in charge completes Emergency Screening Request Form, then contacts Unit Director, Social Worker, or Nurse Supervisor at home stating Mental Health Center's request for immediate placement.

B. Child is admitted according to clinical policy on admission procedure. Required papers completed. Physical and Mental Status done in Admission Suite.

C. Community Mental Health Center is contacted and requested to send, where feasible, a representative and parent or guardian to WCGRH Children & Adolescents Unit at 10:00 a.m. Monday morning.

D. At 10:00 a.m. Monday the Community Health Center representatives, parents/guardians, team members, and other involved agencies meet to discuss disposition. Other agencies were alerted to bring pertinent information on child to this meeting. Necessity of continued hospitalization is discussed at this time.

/s/E. T. ZEITOUNI, M.D.
E. T. Zeitouni, M.D.
Acting Clinical Director

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR JAMES B. CRAIG, taken on the 5th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, Atlanta Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
DAVID GOREN, ESQ.
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For the Defendants: DOROTHY Y. KIRKLEY, ESQ.
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132 Judicial Building
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[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The witness was advised of his right to read and sign his deposition, and he specifically waived that right.)

JAMES B. CRAIG, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A James B. Craig, M.D.

Q And where are you employed, Doctor Craig?

A Superintendent of Regional Hospital in Savannah.

Q And are you also a psychiatrist?

A Yes.

Q And are you board certified?

A Yes.

NOTE: (Defendant's Exhibits Numbers One through Seven were marked for identification.)

Q And would you identify Exhibit One please?

A That's my curriculum vitae.

Q Is that a current vitae?

A Yes, it is.

NOTE: (Brief colloquy.)

Q Now, Doctor Craig, what are your roles and duties as superintendent of the hospital?

[3]

A Well, basically to see that all of the patients are admitted and evaluated and treated and also to arrange for treatment after they leave the hospital through the community mental health clinics.

Q How many counities does the Savannah hospital serve?

A Twenty-four southeast counties.

Q And you also have community mental health clinics within that area?

A Yes.

Q How many of those are there?

A There's four catchment areas, and then we have some satellite clinics in addition to those.

Q And through those clinics are the entire twenty-four counties served in the community?

A They are.

Q What, in general, is the relationship between community programs in your area and the hospital?

A Well, actually, we have four non-medical unit directors, and these people are, say, unit directors at our hospital, and they also double as director of the community mental health clinic, and they visit the hospital at least one day a week and coordinate the activities between the hospital and clinics.

Q All right.

A They usually bring some other people with them, not just the unit director.

Q Do the community programs work with the hospital in the admission process?

A Yes, many of the patients come directly from the community [4] centers to the hospitals. Some of them are by-passed, and eventually you are trying to work toward all of your patients coming through the community cen-

ter before they come to the hospital. There will be rare exceptions no matter how good a system you get, but that's the ultimate goal.

Q Basically in this case we're talking about the voluntary admissions of children and adolescents, and then we make a distinction at times between emergency and non-emergency admissions. What would be, in the great majority of cases, the procedure for admission of a child on application of his parent to the hospital?

A Well, usually they would—occasionally, say, a parent would make application directly to the hospital, but usually they would go through the clinic, or through some other agency.

Q Is this written, as a policy of the hospital?

A Yes, and I think you have a copy of that.

Q Is that Exhibit Two?

A Yes, uh-huh.

Q Okay. Could you just summarize that?

A Well, it actually lists, say, the people who do refer patients and—parents, foster parents, individuals occasionally, D.F.C.S., juvenile courts, vocational-rehab, and then the case is evaluated, say, before he's actually admitted, and many times they are not admitted, they are just evaluated and then other referrals made to adequate treatment facilities—programs.

Q This evaluation you're talking about, would it occur first at the community mental health clinic?

[5]

A If it was a referral from there, yes, uh-huh.

Q And do you know what kind of evaluation this is and who performs it?

A Not specifically, but each catchment area has a person who is a coordinator of the child and adolescent . . . , each one of the four catchment areas.

Q If a child—if a parent presented a child directly to the hospital without any evidence that the child had been through a community program, and the receiving person at the hospital determined that it was a non-emergency situation, would the parent be referred back to the community mental health clinic?

A Definitely so.

Q So your admissions directly to the hospital would be in emergency situations?

A Yes, if it was a direct admission without going through any other agency. It would definitely have to be an emergency.

Q And what are the criteria, in your opinion, of an emergency admission?

A Well, I'll give you an example of one just recently, and I think it was a pretty good example, of a child who had been placed in a group home, and the child became extremely upset, got a butcher knife and threatened one of the house parents and threatened to kill himself, and he was put in jail that night. The next morning several people called us about taking him in the hospital just for an evaluation to see if he was too sick to be in that home, that he needed to be in a different kind of home, and it was just for a respite kind of thing, really. And arrangements are already being made—he's been there [6] approximately one week, and arrangements are being made now to send him to a different group home.

Q Uh-huh.

A And working with the say, people involved in the new home before he's actually sent there, meaning they'll come to the hospital, our people will go out to the home.

Q Basically would an emergency admission involve a situation where a child was dangerous?

A Frequently, and I think occasionally it would be when they had just run away, say, from a group home, their own home, and rather than put them in jail, put them in the hospital as a respite for evaluation.

Q And then an evaluation would be conducted right there . . .

A It would start immediately, yes, uh-huh

Q And a decision would be made within a week, say?

A Yes, I'm sure it would be a week or less. Occasionally it takes two or three weeks for a complete evaluation.

Q I know this is a general question, but looking at non-emergency voluntary admissions, what criteria does the admitting physician look for in deciding to hospitalize a child?

A I think basically that he is convinced that, say, by the fact that he has been tried in other situations and not made it, or maybe, quote, "too sick to even try right then," meaning like if a person was an acute schizophrenic, I think it would be the wrong thing to send him back to a mental health clinic . . .

Q Okay. Would you identify Exhibit Three, please?

A These are the dates and initials of people who were evaluated and were not admitted in 1974—fiscal year '74, '75.

[7]

Q Do you have any policies, Doctor, with regard to treating families and children at the same time that they're admitted to the hospital?

A When a family is available, all efforts are made to get them involved in the treatment. Not only in the treatment, but in the original evaluation.

Q Would they be involved in treatment at a community program or at the hospital itself?

A Either or both.

Q Are you aware of any general reluctance on the part of parents to participate in the treatment program?

A Oh, sometimes, yes.

Q From your experience, do you have any estimate of what percentage of parents are reluctant to participate in the treatment?

A Oh, it would be a pure guess, actually. I'd say if the parents are available and are approached, say, the right way, and sometimes repeatedly, I'd say there would be less than twenty-five percent that wouldn't participate, but again that's just a guess.

Q Can you think of any specific instances?

A No, because I'm personally not directly involved with the child and adolescent program.

Q Okay. What is the physical plan of your child and adolescent program?

A We have forty beds, and it's divided up into, more or less, four sections; the building and including, say, dayrooms and also classrooms.

Q And how many beds?

[8]

A Forty beds altogether.

Q Are the children and the adolescents separated?

A No. Well, I—within the building, not a separate building.

Q But within the building there's a separate place for children and a separate place for the adolescents?

A That's right, uh-huh.

Q And . . .

A But they do get together at certain times of the day . . .

Q Who is the . . .

A Eating time, and school time, etcetera.

Q Who is the physician that's basically in charge . . .

A Doctor Spirioza.

Q Is that a woman or a man?

A Man.

Q Is he a psychiatrist?

A Yes, he is.

Q Would you identify Exhibits Four and Five, please, Doctor?

A Number Four is the linkage of the child and adolescent unit to the community programs. Number Five, staffing procedure for the patients in the child and adolescent unit.

Q Do you have a plan at the hospital, Doctor, for periodic review of in-patients?

A Yes, all of them are, quote, "Staffed originally," meaning, say, not only people involved in the evaluation but also people from the outside and also referring agencies, and this usually occurs within the first three weeks, and after that, once a week. I think it's on Monday. All of the staff get together first thing [9] Monday morning and go over all of the patients and up-date their plans and progress, etcetera.

Q The first meeting within three weeks, you said involves some community . . .

A That's right.

Q . . . people as well . . .

A Uh-huh. (Affirmative.)

Q Do the weekly meetings?

A No. They are invited in when plans are beginning to crystallize for the people to be moved out, and actually, I think in this particular unit, I can't say for sure, it is in the M.R. unit, for sure, when a big staffing is made, there is a list of people that the notifications are made, when the staff is going to be, and who it's going to be on.

Q Uh-huh. Do you have any kind of utilization review where cases are reviewed by persons other than the staff of the C&A unit?

A Yes. A nurse—one of the nurse supervisors is head of this committee, Ms. Jean Cleland.

Q And how often does she review cases?

A It depends on diagnosis. You know, they set out certain standards for if you've got this kind of condition

they have to be reviewed every two weeks, and others every three weeks, etcetera.

Q And who sets those standards?

A Oh, basically, I think it comes from A.M.A., and also . . .

MR. TARUTIS: A.M.A.?

A A.M.A., the American Medical Association. I'm not exactly sure on that, now, but they have a lot to do with it and also the [10] Georgia Psychiatric Association.

Q Would . . .

A And Medicare-Medicaid dictates certain ones that we'll review ever so often, too, don't leave that out.

Q Would all the children in the unit be reviewed periodically?

A Yes, by that committee.

Q By the committee?

A Uh-huh, (Affirmative.) in addition to the review ever week.

Q Is there a set period when each case will be reviewed, or is it . . .

A A set diagnostic category.

Q By category?

A That's right, uh-huh.

Q And do you have any idea what the set period is for schizophrenics?

A No, not right off hand, but I would say probably once a month.

Q What about behavior disorders and transitional . . .

A I wouldn't want to venture to say because we have a list that goes with this . . .

Q Uh-huh.

A . . . the survey and they know which ones to do.

Q Did you bring that list with you?

A No.

Q Doctor, would you identify Exhibit Number Six?

A This is a listing of all the cases by number that have been admitted to the hospital since it was opened in 1970.

Q Who prepared that?

A Medical records library.

[11]

Q Did they have to prepare it manually? That's what it looks like.

A They had the print-out and they had to fill in this manually. They had to review each record to complete these items over here. . . .

Q Uh-huh.

A Because you know, after so many years you store records in a different place than your current records.

Q Now would you identify Exhibit Seven for us, please?

A It's a summary of the information I just referred to.

Q And who prepared the summary?

A The same people in medical records.

Q Did you ask them to prepare it for you.

A Yes, I did. I asked them through Mac Daily (phonetic), who is my administrative assistant.

Q Are you aware, from your experience, Doctor, of any general reluctance of parents to take their children out of the hospital after your staff recommends discharge?

A Yes, you always have a few of these, because with the kinds of, say, cases you get admitted to a hospital, meaning that many times it's because of their disinterest and inability to get along that the child gets sick.

Q What percent of your cases would you guess . . .

A That what?

Q . . . that parents are reluctant to take their children home, do you have any idea?

A I'd guess five to ten percent, but the reason I was hesitating, is on the other side of the coin, some of them want to take them home and they shouldn't.

[12]

Q Uh-huh. What steps do you take if parents are reluctant to take their children home?

A Well, I think first by—if we think, say, it's to the best interest of the child we try to work with those parents, either at the hospital, or through their connections with community mental health centers, because if you make them take them home, you're doing a disservice to the child.

Q Doctor, one of the issues in this case, and one of the contentions that the plaintiffs are making, is that there is a necessity for judicial proceedings prior to the admission of each child to the hospital on the application of his parents. In your opinion, as superintendent and as a psychiatrist, would such proceedings be necessary?

A I don't see where it would be helpful, personally. I think the most important thing is what you do for the

child after he gets there, not how he got there, and basically—well, for at least twenty years, psychiatrists in generally have been fighting to, say, get rid of the court procedures having to do with mental illness, children as well as adults, and treat it as any other kind of illness. And in the State of Georgia, this was first accomplished, really, to my recollection, 1960, when the 1960 Mental Health Act was passed.

Q Is it your opinion that the procedures that you've established for admissions and for screening are adequate to make sure that children are appropriately hospitalized?

A I feel so. Definitely so.

Q At this point in time, is it a policy to treat the children at home whenever that's possible in your medical . . .

[13]

A Oh, definitely so, yes.

Q That's all the questions I have.

A Not only with children, but adults, too.

NOTE: (Brief off the record.)

NOTE: (Defendant's Exhibit Number Eight was marked for purposes of identification.)

Q Going back on direct, Doctor, would you just identify Exhibit Number Eight?

A Eight is a copy of all of the admission papers on the present population of the C&A unit in Savannah, plus a copy of social service history, plus the physician's admission note.

EXAMINATION BY MR. GRANBERG:

Q Let me just ask you Doctor, what's the number of physicians you have at your institution?

A Twelve and a half.

Q Twelve and a half?

A Yes. We have some part time physicians.

Q Okay.

NOTE: (Brief colloquy.)

Q And of the ones that are there full time—well, I guess the ones—anybody who has—is the half time person not a consultant, but he works for the . . .

A On a part-time basis.

Q . . . but he works for the hospital.

A Uh-huh. (Affirmative.)

Q What kind of doctors do you have?

A Well, actually we have pediatricians, internist, one psychiatrist, [14] and another general practitioner, who are part-time.

Q And of all the physicians there, there are twelve, then, twelve full-time and three part-time?

A It amounts to twelve and a half. Some of them are four-fifths and this kind of thing.

NOTE: (Brief off the record.)

Q How many psychiatrists do you have there?

A Eight.

Q And how many of them are certified, board certified?

A One.

Q The others are board eligible?

A All but one.

Q Do you have any child psychiatrists?

A No, not a person who has completed their training in child psychiatry, no.

Q Okay, do you have anybody that is in the process of it? Just in the way you answered that question, I got the impression . . .

A No. See, to be a child psychiatrist you have to have, say, so much general psychiatry, formal training, plus two years of child psychiatry, and we don't have any such person.

Q You don't have anybody who is going through the training, or anything?

A No.

Q Okay. Do you have any foreign born or foreign trained physicians in your institution?

A Yes, we do.

Q Do you know how many?

A Eight.

* * * * *

[17]

* * * * *

Q When was the screening policy of children adolescents unit promulgated, is that the correct date, November 17th, 1975?

A This is when it was written, yes. It was in effect before then, but it was not written.

Q When was it originally in effect, I mean, when did it go into effect?

A I was told shortly after the inception or opening of the unit in 1970. I can't clarify that because I wasn't there.

Q But it wasn't written until November 17th, 1975?

A Not in the present form. They had some set procedures in the nursing manual, some in the general hospital manual, etcetera, but it never was gotten together like this.

Q In regards to Exhibit Five, which is your staffing procedure concerned with which people are going to get involved with review after admission, do you have any kind of—I can see from here it's a wide-ranging assortment of people who said—the memo said could be involved or invited. Do you have anything like that prior to admission, either formal or informal policy?

A Not that I know of in written form.

[18]

Q Well, just in unwritten . . .

A I think if you'll go back to that other one, you have something in that, as far as November of '75—as far as the screening and who participates and who is contacted, etcetera.

Q Okay, but I think—let's see, are there anybody involved—that certainly provides for people outside of the institution to get involved, but . . . wide range of people to get involved, is there anything provided for formally or informally at—prior to admission?

A Not other than what's written, no.

Q Do you think that could be beneficial, do have that wide range . . .

A I think it might. I think it might be an improvement. Can I look at this for a minute?

Q Surely. I guess you'd agree with the fact, just from looking at your policy here and your concern not to admit people unless necessary, especially children, that the more

facts available to the admitting physician, then the better he's able to make a reasonable diagnosis and the better he is to make a decision as—in regards to admission?

A I think that's always true, if it's available at all. I think every effort ought to be made to contact people other than, say, their immediate family, too, and I'm sure it has been done, even though it might not be written down.

Q Can you just briefly describe, and it doesn't have to be very long, just exactly what would happen in the usual situation if somebody out in Waycross or some of the other outside counties [19] wanted to admit his child in a non-emergency situation to your hospital?

A Well, I can just—by citing a case two or three months ago. This mother called me, and I don't know whether her physician or somebody that she was . . . had advised her to admit her child, which it seems to me it was a seven or eight year old girl to the hospital, and my first question was, "Well, who recommended that she be admitted and why?" And she told me who it was, so then my next question went, "Well, has she really had any evaluation on the outside other than this person that you are quoting?" And she said, "No." And she was referred to the—this was the Waycross clinic, and I don't think we ever got the child.

Q So that child would be referred to the community health . . .

A That's right, and they would either treat him or make other arrangements for his treatment, or her treatment.

Q The other arrangements—if the arrangements included institutionalization, would they make the decision

at that point or just make a recommendation to you, to your hospital, that he be admitted?

A You mean the clinic?

Q Yes.

A They would recommend and send us the material —written material if they had time, or communicate by telephone through their child and adolescent worker, and each one of them has one designated.

Q And then the child would be brought to the institution—if they recommended that the child be brought to the institution [20] there would be another . . .

A Evaluation there.

Q . . . would there be a separate . . .

A That's right.

Q Would there be a psychiatric examination at that time?

A Yes, before the child was formerly admitted.

Q There is no psychiatric examination at the clinic level?

A Sometimes it is. Most of your clinics have—well, all of them have at least a part-time psychiatrist.

Q I see.

A Savannah has one full-time and about four part-time.

Q Do you have any type of policies in regards to the conduct of the interview or the—at the community mental health level?

A No.

Q Or any type of policies that you would dictate to the clinic in regards to what facts are to be assembled?

A I think they would be told by whoever—asked by whoever they contacted at the hospital if they had such and such information and be sure to send it ahead or bring it with the patient when he comes for an evaluation.

Q And do you have any policies in regards to the conduct of the psychiatric interview of the child or of the parent at the time—at the hospital?

A No, not any specific policy, and that would depend so much on, say, the situation, the background and philosophy, say of the individual psychiatrist who was doing it.

Q Are you familiar with any studies that have been done—conducted in regards to the method of conducting psychiatric [21] interviews with children?

A Not any recent studies. Of course . . .

Q That's not meant to put you on the spot, but try to draw one out if you can . . .

A No, I haven't been especially interested in child psychiatry for some time, even though I did it for awhile.

Q Do you know of any statewide policy in regards to—promulgated by D.H.R.—Division of Mental Health —in regards to admission procedure?

A You mean that would be put out through Doctor Philley's department?

Q Well, I don't . . .

A He's head of child and adolescent . . .

Q Anybody from the D.H.R., Division of Mental Health?

A Yes, I'm acquainted with some general memos that were sent around on this, but I couldn't tell you the content of them.

Q Do you remember when they were sent around and by whom?

A That would be probably Doctor Philley.

Q Do you remember approximately when they might have been?

A Well, it would have to be in the past year, because he hasn't been here much longer than that.

Q How many children are in the Savannah hospital now under the voluntary admission?

A I'd have to go through the papers.

Q You don't know off the top of your hat?

A No there are twenty-nine there altogether.

Q Okay. And do you know what the average lengt of stay would be for a voluntarily admitted child?

[22]

A I think you could just give the general average length of stay, because I've never seen it broken down as far as the type of admission. The average length of stay is between five and six weeks.

Q And do you know with regards to those children admitted, how many had a diagnosis at admission of some type of transient situational disturbance?

A No, I'd have to look at the summary of that.

Q I'd assume at the time of admission, the criteria for diagnosis is the D.S.M.-2?

A I'd have to see the form to answer that.

Q You don't have any standard . . .

A You mean—you mean actually the . . .

Q For making the . . .

A . . . nomenclature book?

Q Yes.

A It's called the gold book now. Yes, it's gold colored this year.

Q Okay.

A It was gray before.

Q So it is the D.S.M.-2?

A That's right. There's another one on the way out, too.

Q Have you ever had any contact with the Legal Services attorneys down in Savannah, any of the Legal Services attorneys, you or any members of your staff?

A I'm sure our staff has, yes.

Q Do you know if any of them play any role in regards to policy advisement—not policy, child advocacy units or anything [23] like that for periodic review?

A I don't know.

Q Under—according to Exhibit Five, you have quite a few people from the outside coming in to help you initially to evaluate a child's case, and determine, I guess—I would assume, and I'm not saying this specifically, to determine what the type—what type of problem it is and perhaps what alternatives are available for treatment outside of the . . .

A Yes, basically that's the reason for them to come in, including the judges, frequently. Juvenile Court Judges.

Q Oh, they are there?

A Frequently, not always.

Q Do these people who are invited to come usually come as a practical matter?

A Quite a few of them do, yes.

Q Who are the ones that come the most?

A I'd say the people from, say, the community clinics.

Q And this—would this hold true for the ones—the—for the community mental health clinics out in, let's say, the counties, further out in the counties?

A Yes, they come from Waycross frequently. That's a hundred and ten miles.

Q Do you think it would hurt you if you had another person there at these meetings to serve as a advocate for the child in regards to his legal rights?

A I think it would depend on who the person was and how they conducted themselves.

Q Certainly. I meant—I should have said as a given—it's [24] not—the purpose is not to disrupt the proceedings . . .

A No, if it was for the purpose of helping, I don't think we would have any objections. I think at times it would help.

Q All right. Do you think that state-wide the other—the other hospitals should have a program like this which involves outside persons like the ones we just talked about on a regular basis?

A I'd be biased, but I don't think we need it.

Q You don't think what?

A I don't think it's needed.

Q Oh. You go the extra step?

A Yes, I think so, because we make every effort to get the child out.

Q These people that come in—I want to make sure I've got this right chronologically. They come in within three weeks of the admission date . . .

A Uh-huh. (Affirmative.)

Q . . . and then they're invited in again . . .

A When some change is indicated by the weekly meeting that the staff has.

Q A change in regards to what?

A Plans in treatment, disposition. Meaning as a child goes along, you can't always predict what he's going to need, say, a month from now.

Q Could it be just a plan—change in treatment at the facility . . .

A Well, if it was that it wouldn't be as necessary for them to [25] come in as it would be in a planning for future treatment outside.

Q Okay. Basically, then, these people are invited in when you're talking changes as to a different modality . . .

A That's right.

Q . . . outside of the hospital . . .

A Not just every change in the hospital.

Q It's usually a change . . .

A But we don't object to them knowing that, and if they do come, fine.

Q Just one question about the utilization review com-

mittee. How often are the children and adolescent cases reviewed?

A I think . . .

Q Is that the thing that's based on the diagnostic categories?

A That's right.

Q Okay.

A That was all set down by . . .

Q Okay. The example you gave of a child who had been involved in a potential knifing, or an attempted knifing, you said he was there a week and . . .

A Well, he's still there. He's been there a week, and they staffed him yesterday with the community people from Brunswick, and plans are already being evolved where he will go to another group home in that area, but not the same home.

Q Do you know which group home that is?

A The one he's going to?

Q Yes.

A It's the one in downtown Brunswick.

[26]

Q Okay. Now, what particular relationship do you have with foster homes and group homes there? It seems, from looking at your—that summary sheet, that you do place a lot of children in group home settings?

A Actually, our people usually do not do the actual placement. It would be D.F.C.S.'s policy, supportive home—supportive living program . . . foster homes.

Q How does D.F.C.S. get involved? Do they come to these staff meetings?

A Yes, they frequently do, and they sometimes have custody of the child.

Q And would they base that on your recommendations—should say—they might have custody of the child before he's admitted, or are you talking about situations where you'll make a recommendation that they bring an action to terminate parental relations?

A No, the latter would be rare. The former is usually the case, where they actually already have custody.

Q Okay, even considering the situation you have there, I imagine there are times though, when the—perhaps the doctors determine that a child no longer needs hospitalization, yet the child is not released to an alternative outside the hospital or at least drastic—less drastic environment because there are no other alternatives available outside of the hospital?

A I think one of the things needed in this state along these lines is group homes specifically for adolescents. As far as I know we don't have any. (To Ms. Kirkley) Do you know of any? [27] The department is working on this now.

Q The Department of Human Resources?

A Well, the Division of Mental Health. I can't speak for the department. But I think you have to pursue more than one avenue to try to get people out.

Q Surely. One thing you said about judicial proceedings, was that the most important thing, the thing—what you do when the child gets there, when he gets to the hospital, not how he gets there.

A Uh-huh. (Affirmative.)

Q Okay. Do you have—is there some concern, though, that if it's important that the child shouldn't be there to begin with, to make sure that he isn't admitted?

A I think if he really shouldn't be there at all we don't admit him.

Q Okay.

A Meaning this group in this Exhibit. (Indicating Exhibit Three.)

Q Oh. Do you think judicial attitudes in regards to mental health laws have changed in the last twenty years or so?

A Whose attitudes, now?

Q Judicial attitudes.

A Yes, according to the literature they have.

Q Okay. As a matter of practice?

A Yeah, I think all the, quote, "rights of patients" we read about, and I think try to conform to, and I think do, but as far as judicial commitment, if I might say so, I think is a step in the wrong direction.

[28]

Q Okay. Because . . .

A Meaning I went through this for twenty years.

Q Okay, are you saying because your procedures are adequate?

A Yeah, uh-hum, in the safeguards of the patients, I think I have . . .

Q All these procedures that you've institutionalized, procedures for . . . safeguards and policies that you've shown us in the various exhibits here, those were all implemented by you or your predecessors, or . . .

A Yes, by me or my predecessors.

Q Okay. But they aren't incorporated as a matter of state law or regulation, are they?

A Not that I know of.

Q So they—these policies are subject to change, or could be changed in the future?

A Yes.

NOTE: (Brief colloquy.)

Q What is the average case load of each physician at your institution?

A Oh, it varies within the units, really.

Q All right, let's start at children and adolescents, then.

A Well, the capacity is forty, and it never runs forty.

Q Does he have any other cases that—is he responsible for any other cases other than those in the children and adolescent unit?

A Not in the past six months.

Q So he's concerned solely with the . . .

A Well, I'll elaborate on that a little. Prior to six months ago [29] he had to take, quote, "his regular rotation in the alcohol unit" because of the big load. That was discontinued. Up until, say, approximately one month ago he had the medical responsibility for approximately thirty-five other cases in M.R., but not as far as running the M.R. unit. Now he does not have that.

Q So what he's got—his only cases are those in the C&A unit?

A That's right.

Q What about the other doctors, do you have any idea what their average case load might be?

A Oh, let's see. The Brunswick unit, it varies a little from unit to unit, but it wouldn't be more than forty; probably thirty or thirty-five. And the Medical Infirmary would be ten. Chatham-Effingham would average about thirty-five. Alcohol would average around fifty.

Q What—in your role as the chief administrative officer of the hospital, the superintendent, what do you think would be, like, the ideal number of cases per physician?

A I don't think our physicians are over-loaded.

Q Okay.

A Maybe because I've worked at other places where they had so much more to do.

Q Did you say, like, in the children and adolescent unit, that—what he's doing, the capacity—there were . . .

A Forty.

Q . . . forty, that would be suitable?

A I think so, along with, say, the other professional people that he has, psychologists and social workers, school teachers, [30] etcetera.

Q Are children admitted pursuant to the voluntary admission statute, are they ever admitted due to problems involving the entire family?

A Oh, I think you could talk about that a long time. I think . . .

Q Well, let me just phrase it another way, then. Is it—listening to your testimony on direct, do family problems often result in the parents trying to voluntarily admit the child?

A If I had to answer that a yes or no, I'd say no; but I think it needs a qualified answer.

Q Okay, please qualify it.

A Meaning that I think everybody realizes that children frequently become emotionally upset because their parents are not getting along good together. I think frequently as we say, the family is sick along with the child. If you take this into consideration, the answer would be yes sometimes, yes.

Q Okay. In regard, then, to . . . could you say—would it be fair to say that the interest of the child—the child may be—his parents are trying to voluntarily admit him pursuant to the statute—the interests of the child are sometimes at odds with the interests of the parents?

A You mean that it's not primarily for the good of the child, the necessity of the child being admitted?

Q Well, that's one aspect of it.

A Uh-huh. I'd say no, I think we would detect this, say on screening, really.

Q Okay.

A I think what you're getting at is they're just dumping the child [31] to get the child out of the way.

Q Well—okay, I assume that—those kind of situations can happen, that it's possible to stop those situations, to catch them, but I'm not trying—I'm not saying—I'm not talking categorically that's not—that's the only thing. I'm just saying that there is a potential—is it true that there could be a potential conflict of interest between parent and child in these types of situations?

A I think so, but I still think we would be likely to catch it on screening.

Q I have no further questions.

END OF DEPOSITION

* * * * *

EXHIBIT 2

#225-23
[1] 17 November 1975

GEORGIA REGIONAL HOSPITAL AT SAVANNAH
CHILDREN AND ADOLESCENTS UNIT
SCREENING POLICY OF CHILDREN AND
ADOLESCENTS UNIT

Purpose: to delineate screening procedure for admission to Children and Adolescents Unit

The Children and Adolescents Psychiatric Unit of the Georgia Regional Hospital at Savannah has a capacity of 40 beds. The unit provides in hospital psychiatric services to children and adolescents between the ages of three years and 16 years, six months with mental, emotional, and behavioral disorders not amenable to being served by any existing outpatient facility. Patients admitted to this unit should not have a physical condition beyond the capability of the Medical-Surgical Unit to handle, nor have an intellectual ability permanently below the mild mental retardation level.

Applications for admissions and referrals are accepted from other hospitals, mental health agencies, institutions, juvenile courts, educational and correction institutions, vocational schools, children's homes, group homes, professionals such as psychologists and physicians, parents, foster parents, and in special cases, the individual youngster.

The unit is directly accessible to the public by telephone, mail, and actual walk-in. The admissions screening group is a part of the unit team: the psychiatrist, two social workers, a psychologist, and the nurse in charge of the unit.

Craig Defendant's Exhibit Number Two
JMW 12/5/75

The two social workers on the unit receive all inquiries, referrals, and applications directly during regular working hours; after duty hours the nurse in charge will receive such inquiries through the hospital Admissions Office.

Each inquiry is immediately handled. Information and appropriate help is provided at the first contact, especially if another agency appears to be more suitable to meet the needs of the requesting party.

A screening journal is maintained on the unit. Each inquiry or referral is entered by means of a short note by the screening staff listing: names, telephone numbers, and addresses of the inquiring person and of the prospective patient. Also included are essentials of the particular case and the action taken to assist the inquiring party.

Referrals with recommendations for admission, for purposes of a psychiatric workup and/or treatment, coming from a court, a hospital, a physician, or a Comprehensive Mental Health Clinic are accepted without delay. The requesting party is instructed about the legal requirements that a patient who is a minor must be accompanied by a parent or legal guardian at time of admission for purposes of signing application, admission documents, and providing anamnestic data.

Requests for admission not signed by a physician are subject to a more complex screening procedure starting with immediate measures taken by the social worker to research and complete every possible pertinent information about the case, [2] previous psychiatric treatments and recommendations, follow-up, and within 24 hours the case is presented to the psychiatrist with every effort to have a pre-admission interview with the patient and accompanying person included in the screening process. The

SCREENING POLICY OF CHILDREN
AND ADOLESCENTS UNIT #225-23
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decision for admission is given by the psychiatrist after deliberation with the involved social worker, nurse in charge, and psychologist.

The requesting party is instructed to proceed with the admission by presenting themselves to the Admission Suite of GRH/S. The Admission Suite is immediately notified by the social worker or by any other member of the unit's screening group about the decision to admit this patient.

If the admission is denied by the screening group or refused by the patient or accompanying parents or by the custodian, appropriate advice is given by the involved screening staff regarding alternatives to hospitalization and practical measures offered to establish the first contact of the patient with the alternative agency. A final note in the screening journal is written by the staff with clear description of the situation at this stage of the screening, and the case is temporarily closed.

The screening journal is a confidential part of medical records, kept on the unit under the custody of the social worker in chief during two calendar years. At the beginning of the third year, the screening journal is properly destroyed.

In seven to 21 days from the date of temporary closing of any case not admitted, an attempt is made by the responsible social worker to contact the patient, parents or custodian, or referring agency and offer additional help if necessary.

/s/ J. B. Craig, M.D.
Superintendent

/bs
Dist. All MED Units

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR EVERETT C. KUGLAR, taken on the 5th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
DAVID GOREN, ESQ.
STEVE GRANBERG, ESQ.
Georgia Legal Services Programs
Macon Regional Office
653 Second Street
Macon, Georgia 31201

For the Defendants: DOROTHY Y. KIRKLEY, ESQ.
Assistant Attorney General
Department of Law
132 Judicial Building
Atlanta, Georgia 30334

[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The witness was advised of his right to read and sign his deposition and he specifically waived that right.)

EVERETT C. KUGLAR, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

NOTE: (Defendant's Exhibits Numbers One through Four were marked for purpose of identification.)

Q Would you state your full name for the record, please?

A Everett Clark Kuglar.

Q And you are a medical doctor?

A Yes.

Q Are you a psychiatrist?

A Yes.

Q Are you a board certified psychiatrist?

A Yes.

Q Would you identify Exhibit One, please?

A Yes. This is a brief biographical sketch.

Q Is that current?

A Yes, with the exception of the fact that I am now Lieutenant Colonel of the Medical Corp of the U.S. Army Reserve, instead of Major, it's current.

[3]

NOTE: (Brief colloquy.)

Q And where are you employed, Doctor Kuglar?

A Georgia Regional Hospital at Augusta.

Q And what's your position there?

A I am the superintendent.

Q How long have you been the superintendent?

A Since 1969.

Q When was that hospital opened?

A In 1969. I essentially came on board about the time the hospital opened.

Q All right. What are your roles and duties as superintendent of the hospital?

A The roles and duties are the direction of all programs at the Georgia Regional Hospital at Augusta, and also those mental health programs for which the hospital and the division in the department, contracts with local health departments in our area.

Q How many counties are in the area?

A Thirteen counties.

Q And how many community mental health clinics are there?

A There is one complex of community mental health clinics located at the Augusta area. This means more than one center site. We also have—of the twelve remaining counties that we serve, we have a satellite-type program in ten of those twelve counties.

Q But the community program is centered in Augusta?

A Yes, with satellites in the small—the way we are geograph-[4]ically located . . . catchment area of three hundred and twenty-five thousand. Approximately two hundred and twenty-five thousand of those people either live in or within ten miles of Augusta. The other hundred thousand live in these twelve rural counties, a distance which is approximately one hundred and thirty miles by

sixty miles wide, pretty well scattered with no population density, counties ranging from two thousand with the next largest county being eighteen thousand.

Q Are you also affiliated with the Medical College of Georgia?

A Yes.

Q And what is that affiliation?

A Okay, the affiliation is that I hold a title there, Clinical Associate Professor of Psychiatry. We, the hospital and the division, also have a contract with Medical College, so that students in the— during their rotation in psychiatry, residents in psychiatry, residents in family practice, rotate through our hospital.

Q All right. Now, would you describe, please, Doctor, the admission policies for the hospital, with specific reference to voluntary admissions of children and adolescents.

A Specifically to those. There are the following ways that I see it that we can be approached regarding admission. This might simplify going through all the admission policies. First of all we can receive a court order for the admission of a child. Generally we are notified by the court or by some type of case service worker on this, and the child is brought to the hospital. Upon this type of admission the child is always admitted for an evaluation and the court is notified within [5] a reasonable period of time, usually one to two weeks. That is one type of admission. The other type of admission we want to talk about is voluntary admissions to the hospital. In voluntary admissions to the hospital, most of the time the people who are seeking admission would be the parents. This is not necessarily always true, it could be a guardian

or this kind of thing. Insofar as is possible, all of the children, prior to any admission, are brought to the C.A.A.P, or Children and Adolescent Program. We use the initials C.A.A.P.—C.A.A.P., which is part of our mental health center. This part is located in a separate building on the grounds of the hospital, where they are evaluated prior to the admission. This program was opened in April of 1974. We have statistics from April of 1974 to November of 1975 that shows that we evaluated three hundred and fifty-eight patients in this program. Forty-nine were admitted to the hospital, and three hundred and nine were either treated as an out-patient or some other alternative to hospitalization was used.

Q Doctor—do you have those statistics with you?

A I have this. I called and got those from my secretary since they left those out and I knew we had them. (Indicating notes.)

Q Who prepared those figures, Doctor?

A These were prepared by—basically prepared by Doctor Dorothy Wood and her staff, who is the director of our children and adolescent program . . .

Q Excuse me, the director of the program at the hospital, or the community level?

A She is—she is the director of the overall child and adolescent program. The sub-parts are in-patient care, for [6] which the in-patient unit chief, who is a Master's degree nurse, Mrs. Mamie Hammock, and the director of the community program is a Ph.D. psychologist, Doctor Jessie Hawk.

Q So for all the voluntarily and non-emergency admissions, they would be screened first by the community component of the program, is that correct?

A Right. There are an estimated—and all we can do is estimate this—in the past—same period of time from April of '74, there were approximately twenty-eight admissions where these children were brought, mostly by their parents, to the hospital, after five-thirty P.M., and they were admitted to the hospital for an evaluation. We have some bar graphs, statistics somewhere—you have them—I have them here, showing how long admissions were to the hospital, etcetera.

NOTE: (Defendant's Exhibit Number One-A was marked for purposes of identification.)

Q All right, Doctor, would you identify Exhibit One-A?

A Yes. This is a bar graph representation of the length of stay in terms of days in the hospital spent by patients in the children and adolescent year—children and adolescent unit during the fiscal year 1974-'75.

Q And you were discussing, just before we introduced that, admissions for evaluation.

A Uh-huh. (Affirmative.)

Q Does the graph show that?

A What I was showing here is that each one of these blocks represent a patient for this period of time, and it may, [7] instead of—we can count them, I guess, since I didn't write this down—one, two, three, four, five, six, seven, eight patients stayed from one to five days, sixteen patients stayed from six to ten days, eleven patients stayed from eleven to fifteen days, twenty patients stayed from sixteen to twenty days, eight patients stayed from twenty-one to twenty-five days, six patients from twenty-six to thirty days, six patients from thirty-one to thirty-

five days, thirteen patients from thirty-six to forty, six patients from forty to forty-one days, three patients from forty-six to fifty days, nine patients fifty-one to fifty-five days, three patients fifty-six to sixty days, four patients sixty-one to sixty-five days, three patients sixty-six to seventy, two patients seventy-one to seventy-five, two patients seventy-six to eighty, four patients eighty-one to eighty-five, the next patient—there was one patient who stayed from ninety-one to ninety-five, three patients ninety-six to a hundred, one patient a hundred and one to a hundred and five, three patients a hundred and eleven to a hundred and fifteen, there was one patient that stayed from one twenty-six to one thirty, one, one thirty-six to one forty-five, (sic) one, one forty-one to one forty-five, one, one forty-six to one fifty, one, one fifty-one to one fifty-five, one patient one sixty-one to one sixty-five, two patients one seventy-six to one eighty, and one patient two hundred and fifty-one to two hundred and fifty-six days.

Q Okay. Now the ones for these short periods of time, like say less than two weeks, would that basically be your evaluation?

A These are—these are primarily evaluations and short-term [8] treatment patients. Many times we feel that—we personally have a philosophy that children should stay in the hospital no longer than necessary, and we have, as you see, a fairly large number of kids who are out, certainly within two weeks to sixteen days.

Q What procedures and steps are gone through when a child is evaluated at the community component?

A Okay. At the community component, which we will see any patient during the day they call, or if people feel they can wait till the next day, or they can walk into the

program itself, a person is seen by an intake worker. This always occurs. If we are doing a complete evaluation at that time—the person is always seen by a psychiatrist. A complete psychological evaluation on this child may or may not be done on that given date depending on whether it was an emergency or not. There is a decision between the team members as to what is the best alternative for this particular individual, be it hospitalization, out-patient treatment, or other alternatives which would be used.

Q Who would be involved in that team decision, Doctor?

A The intake worker who is either a Bachelors or Masters level individual, the psychiatrist, the director, who is a Ph.D. psychologist, and the testing psychologist, who is usually a Masters degree psychologist.

Q After their evaluation, if they felt like hospitalization was indicated, would they be making a recommendation to the in-patient component, or would it be an actual admission decision?

A They would be making a recommendation to the parents of this particular child.

[9]

Q And then would the papers be sent—if the parents decided to apply, then the papers from the community component would be sent to the hospital?

A Oh, yes. Basically it's all the same program.

Q It's all . . .

A We are a little unique in that we probably, I think, have the most unified system as far as community-hospital program.

Q Would a separate decision be made by a psychiatrist within the in-patient unit?

A No. The psychiatrist who evaluated is the principle psychiatrist on the in-patient unit also. There are consulting psychiatrists that come to the in-patient unit, but he is the principal psychiatrist for both the community program and the in-patient unit.

Q Would a psychiatrist always see a child in the community program, or might he be evaluated . . .

A No, the psychiatrist would always see the child within the community program. This is one of our prerequisites. Let me add at this point, that a consulting psychiatrist is always present at the staffing of this child, which gives us a second psychiatrist opinion, and this is always true.

Q When does the staffing occur?

A The staffing of the patient always occurs within ten days, attempted seven days, from the time of admission. Staffings are held weekly, and therefore the longest possible period would be—the staffing is held on either Thursday or Friday, I'm sorry, I'm not sure which day, but the longest possible time that could ensue between the complete staffing [10] of this patient, the treatment plan, all this is spelled out in the policy, would be if the child was admitted the first of one part of the week to the last of the following week.

Q And who would be involved in the staffing of each case?

A Involved in the staffing of each case are the following individuals. The in-patient chief, Ms. Hammock, the out-patient community chief, Doctor Hawk, the unit

director, Doctor Wood, the team chief of the particular unit which houses this child, the psychiatric social worker assigned to the unit, the psychiatrist, which is Doctor Clark, and one of our three consulting psychiatrists.

Q And a staffing occurs each week . . .

A Uh-huh. (Affirmative.)

Q . . . in regard to each patient?

A Right. And the attempt, of course, is to have the child staffed the same week. Obviously if he came a day or two days before staffing he would get staffed the next week.

Q Would you identify Exhibit Two, please?

A This — these are mimeographed pages from the policy manual of the children and adolescent unit, pertaining to the philosophy, the plan of service, the admission, the treatment plan, etcetera for the children who are in the hospital.

Q Does it include a written statement of the admission policies . . .

A Yes, uh-huh.

Q . . . discussed? Does it include any material with regard to the treatment of the family of the child who is admitted?

A Yes.

Q What is your policy with regard to family treatment?

[11]

A Our policy in regard to family treatment is that we make every effort possible for every child who is admitted into the hospital, to have the family involved in treatment. We have a weekly group meeting of the parents who are there as well as individual sessions with the social worker or with others of the family members. We discourage, almost, the admission of a child unless we can get the family to participate in this. Now we sometimes would have to admit the child, but we use every mechanism to try to get the family involved in this treatment process.

Q Would you have any opinion or estimate, Doctor, with regard to how many natural parents or families do not participate in treatment?

A Yes, about ten percent.

Q And this is after you've tried to get them involved?

A Yes. I think sometimes it takes a little bit of elaboration. We have about ten percent problem families in this respect. I don't think we give up. Sometimes we have to catch the family even if we may have released the child from the hospital and they're bringing the child to the out-patient or community portion we try to get them into treatment, even though we couldn't during the one, two, three weeks the child was in the hospital.

Q Do you find any problem with regard to parents being reluctant to take the children back home after you recommend discharge?

A On rare occasions we do. I'm sure we could recall a—two or three or four episodes during the last three or four years where this was a problem, but it's rarely a problem.

[12]

Q Even with regard to the majority of that ten percent that don't participate in treatment?

A Right. This is the kind—the ten percent is the kind of thing, like the parents keep finding excuses why we can't come, or I can't get off from work, or this kind of thing.

Q Would you identify Exhibit Number Four?

A This is the utilization review plan for the Georgia Regional Hospital at Augusta and includes all units and programs including the children and adolescent unit.

Q And how does that process differ from the staffing process?

A A utilization review is essentially a review program using the patients' medical record to ascertain that hospital-wide policies, goals and objectives, which are spelled out by the hospital, by certain Federal regulations concerning Medicare and Medicaid, are being met.

Q And who conducts the utilization review?

A The utilization review? This is conducted by a committee, with the superintendent and the clinical director being the chairman and co-chairman of this committee, with physicians and other professionals being appointed to this committee. It meets monthly. We brought, and we may want to xerox some of this stuff—but we brought the minutes of the meetings, and the only way to do this would be to xerox the pages—for instance showing the involvement in specific meetings. This was the last one, the November meeting has not been typed and put in here yet, but we notice, for instance, in the October meeting that Doctor Hawk, who we've identified previously, "informed the group that the explanation of the [13] patient's right on the children's unit will be documented by the social worker on the progress note sheet. The medical records department is documenting this information on

the back of the admission sheet. We also noted that Doctor Hawk has asked that the children and adolescent community services center records be included in the utilization review. These are out-patient records, so to speak, to be included in the utilization review. It was the consensus of this committee that these records be incorporated in the monthly review." Of course, it lists which records are.

Q It is a random selection of records for each . . .

A Right. Right. Except that there's a number of days that the patient is in the hospital, and I forget this number, we'll have to dig it out of here somewhere—various time periods that these records have to be reviewed. This is a Federal requirement of Medicaid, and we therefore try to treat all patients equally, so at some of these intervals, whatever it is, a hundred days or something like that.

Q So all cases would be reviewed at least that often?

A Uh-huh. Now I would point out, as it's spelled out in the policy, that on the unit, during the weekly—there is a weekly conference, an on-going conference on each child or adolescent who is in the program, because a treatment plan has been devised initially with a goal as to the time of release, an expectations, and each week a conference goes over this to see, you know, if we're meeting the goals or if the treatment plan needs to be checked, and this kind of thing, [14] so basically an in-patient child is reviewed by a team conference consisting of these same members each week.

Q Is one of the goals of that team conference to try to make release plans?

A Yes, but essentially release plan concepts are made

as part of the initial treatment plan when a person comes into the hospital. It's currently felt, that in your initial treatment plan, you should also be planning for the release of this patient, with some idea as to how long the person would be hospitalized, and this kind of thing, and therefore we use a weekly monitoring system to follow this treatment plan.

Q Now would you identify Exhibit Number Three, please?

A Yes, Exhibit Number Three is a list of all individuals who have been admitted to the Georgia Regional Hospital at Augusta since its opening, who were less than eighteen years of age. It's through age seventeen. It gives the date in which they were admitted to the hospital, the date in which they were released, whether they were directly discharged, placed on convalescent leave, and when, if they were placed on convalescent leave, they were directly discharged from the service, the building they were in, ages and other things like this, and we went through the records and have noted on the side to whom this particular person left the hospital or was released to, the parents or service worker, or what-have-you.

Q Initially, was this a printout from the computer at the hospital, is that correct?

A Right.

Q And then notations in hand were put on by manually checking . . .

[15]

A Right, the medical records. We then pulled all of these charts and went through this on this side. We simply used a computer using an age factor to make the original printout. And there is, attached to it, a code sheet which

will identify, give you, I guess, instructions on how to read that bunch of numbers.

NOTE: (Defendant's Exhibit Number Five was marked for purposes of identification.)

Q Would you identify Exhibit Four, please?

A This is the utilization review plan for the entire hospital which also includes children and adolescent programs.

Q This is the policy that we've been discussing . . .

A (Nods in the affirmative.)

Q . . . is that correct?

A We've been discussing two policies, really. There is the specific policies pertinent to what we're talking about from the children and adolescent unit, which is in one folder; this is the utilization review plan, which is a specific requirement that covers the whole hospital including that unit.

Q And this is the one in which cases are selected at random . . .

A Uh-huh. (Affirmative.)

Q . . . each month . . .

A For the utilization review committee, and it spells out how this committee is formed and . . .

Q And would you identify Exhibit Number Five, please?

A Exhibit Five contains the admitting physician's admitting note and the social history of all children and adolescents who [16] are hospitalized by eight A.M. December 1st. I think there are twenty-three or twenty-four in there.

Q What is the size—the number of beds in your C&A unit?

A Maximum number of beds is forty.

Q And as of December 1st you had twenty-nine patients?

A On the morning—well, we took this on the morning of the first, we had—I think there's twenty-three there.

Q Oh, twenty-three, excuse me.

A I believe that's correct. There may be twenty-four or something. We run an average for that unit, average daily census of about twenty-seven.

Q Are the children and adolescents combined together physically?

A They are—they are housed in a building which has four segments. One segment is designated for family living. This segment of the building is designed as much like home surroundings as possible. Children who are in the hospital for a period of longer than approximately ninety days, live in this unit. Another unit is for younger males. These are males who are generally less than thirteen years of age. We do have flexibility in that a very small immature fourteen year old might be placed there, or a very large husky twelve year old might go. Another unit houses what we—generally older females, or if a younger female were admitted she would be on that unit, but another definite one is the older males, which are males generally thirteen through sixteen or seventeen years of age.

Q Now could you just describe a little bit more in detail the differences between the family living section and the main [17] portions of the unit?

A Okay. The main portions of the unit where patients are admitted according to sex and age within the living confines of the unit, we consider more our diagnostic unit, our acute treatment unit, this kind of thing. One difference is it's typically furnished with institutional-type furniture such as we see in this room, as compared to the other one, which as a very home-like atmosphere with curtains, wooden tables and this kind of thing. The other—the main unit is staffed—the primary staff, nurses, attendants, etcetera, are on a shift-type basis. We try to use a house parent or parent image type of approach in the family living unit.

Q Is there also a school room?

A The school is a part of our program not located in this building. We have a school which has six or seven different classes where children are geared through age—soon after admission as possible, this might be day two or three—the child is fitted into the appropriate classroom where he stays during the usual school day, you know, from eight or eight-thirty to two-thirty or three, or something, assuming he can, or he may be there only a few hours a day, and this kind of thing, but a school is a part of our program.

Q Do the children and adolescents attend school together?

A They attend school together but there are seven different class categories. We've got something like basically a first, second and third grade, this being a small number of kids; then there's a fourth and fifth grade; sixth, seventh and eighth grade, ninth; tenth; eleventh; twelfth.

[18]

Q How many teachers do you have?

A We have one for each classroom . . . teachers. We use our—we either have a teacher's aide, or by virtue of the children being there we use a nursing assistant-type person to serve as an aide, or as a principal for the school.

Q One of the contentions in this case, Doctor, is that there needs to be a judicial proceeding prior to the commitment of children to the hospitals. In your opinion as superintendent, do you see any necessity for a judicial proceeding as a screening process prior to the admission of children?

A No, I don't see any reason for this. There are children who are admitted by this process. My contention for feeling this is not necessary is, first of all I think any program, and certainly we try to do this, no one should hospitalize a child unless this is in the best interest of the child and the total family situation. The goal should always be immediate treatment and release of this child back into the family setting. The big handicap, it would seem to me, if we had a judicial process, would certainly be immediately, in any type of emergency situation, where this would require time, and secondly, if we assume that we have any validity at all in which children should be admitted to the hospital, I wonder about the feasibility of putting the parents through the added necessity of going through a judicial process. It would be rare indeed for us to ever put a child in the hospital whereby the parents didn't want to. This would be the one time, and I can only think of one occurrence where we're used it, where we felt this was in the best interest of the child, and [19] had the Family and Children Services workers apply for an admission to the hospital, so certainly one of the things that's going to be necessary to help ninety-plus percent of our children is the cooperation of the parents

both in participating in treatment and following their wishes and this kind of thing.

Q That's all the questions I have.

EXAMINATION BY MR. TARUTIS:

Q Doctor Kuglar, you indicated that—that for the initial admission there is an evaluation team as part of the community component of the C.A.A.P., is that correct?

A (Nods in the affirmative.)

Q Where do they obtain the information that they rely upon for their initial evaluation?

A Well, the information, obviously, would depend upon the circumstances, but the information in general would come from the parents of the child and the child itself. Now there may or may not be court service workers, or D.F.C.S. workers or these kind of people involved in the case, so they would gather as much of this information as they can from these people, so it would obviously depend upon why the child was coming there, whether the parents were calling up, or a referring physician might make it, and we would get some information from him as well.

Q When a child comes to the community component, I think you said he basically comes from or through the community health clinics in the outlying area first?

A Yes.

[20]

Q This is ninety percent of the cases?

A Right.

Q What would be the normal situation for someone coming from the furtherest county that your regional hospital would cover? How far would they have to travel to the community health clinic and approximately how far is your hospital?

A Right. That's—all I can do is give you a hypothetical example using this county and this kind of thing.

Q Okay.

A The furtherest one would be the two southern counties, which are Emanuel and Screven counties, Sylvania and Swainsboro. Now let us assume that the parents or a D.F.C.S. worker wanted a child seen, whether they wanted—may call and say they want the child in the hospital and this kind of thing. In these counties our first line worker, of course, are the public health nurses and some general mental health workers that we have out there. We try to look in on a situation right then. We have teams that go to these clinics once weekly, therefore if it wasn't an emergency, they could be seen by this—by a team consisting of a psychiatrist, a nurse and a social worker who goes to this county. If by the phone it was felt that any sort of an emergency existed, then they would bring the child to the mental health center for an evaluation.

Q The—the team—let me see if I have this right. The team would then leave the regional hospital and go to the local community mental health clinic . . .

[21]

A Right.

Q . . . for an appointment to evaluate or interview the juvenile or adolescent or child . . .

A And the family. Let me take a minute or so to clear this up. We have two geographic areas. All right, our adult programs, or our general programs, so to speak, are on this geographic area. We're primarily talking about the rural counties now.

Q Right.

A Okay, now this is different from this child team. We have a general psychiatrist, board eligible, unless he has gotten his certification within the last few weeks, a psychiatric social worker, a nurse; they are scheduled to go to each of these counties once a week. They are following patients, seeing patients, and adults or—and/or children in this clinic, so that the public health department, or an agency such as D.F.C.S., is the normal way, or a family physician—in which normal way somebody would get linked in with the mental health services. What—since we have these public health nurses there that we work with closely, we try to get these people, or sometimes the D.F.C.S. worker, you know, immediately involved in that county. If it's not an emergency, when our regional team goes out on a scheduled day, they will see this person. If there's any feeling that there is an emergency, we would get this person to a mental health center at Augusta, the seventy mile distance, that day or the next day, this kind of thing.

Q Pardon me for interrupting, but what would you mean by an emergency? You probably should define that term.

[22]

A What might we mean by an emergency?

Q Right.

A Where parents have found an adolescent suicide

note, or if some attempt at suicide, there seems to be a great deal of panic on the part of the parents. We consider this an emergency. This sometimes happens.

Q So then after the evaluation team interviews this person, the family and the child or the guardian and the child, they would—if they then decided that institutionalization might be indicated, would be their next step?

A You mean out on the regional . . .

Q Right.

A To send the child to the mental health center.

Q And then they would go through the process that you described?

A Of evaluation, right, of gathering up as much data from the child, the parents, and other people or agencies as we can get to validate or assist this, family doctor, D.F.C.S. worker, court service worker, public health . . .

Q How would you—how would you get that information?

A We generally get that information by telephone.

Q Who would do that, the intake worker, or the . . .

A Well, I think they sort of may split this up. If we've got a child like this with more than one person to call, they might split this up. Basically a Masters level psychologist is usually the person in the childrens unit who tries to round—that person and a social worker, these two people sort of split it up, but we might have all of them according to a given case.

Q When we were talking about the admission procedures earlier in [23] your direct examination, you mentioned, or at least I understood from your testimony, that

you understood that—that we were discussing it in the context of forcing the institution to take the child rather than acting as a buffer to the institution from being required to take the child.

A I'm sorry, I'm not sure I'm following you.

Q Okay. Let me rephrase the question. Do you feel that it would be helpful, as part of this intake process, the initial review by the community component, that as part of the team, or as part of the review procedure in regard to evaluation for commitment, there was a non-mental health related person involved in that evaluation?

A I don't know if I think it would be helpful. I don't know that we object—I would object to it in any sort of way.

Q It wouldn't be—you wouldn't see it as being harmful or detrimental?

A Uh-uh. (Negative.)

Q Do you—what about the—after the child is then admitted, as I understand it, you said there would be a consulting done—a staffing done within approximately seven to ten days after the admission, depending on what day the child was admitted to the institution?

A Yes, and I think this depends upon the complexity of the given child and this kind of thing. As I said, our goal is to have this staffing on the same week that he comes in, and there are certain cases where he may come in the day before staffing and be staffed at the staffing the next day. The maximum time he can wait is till the staffing the next week, in other words, [24] that's the maximum length of time.

Q All right. And basically, the people involved in the

staffing are all health professionals, as I understood it, there is the psychiatric social worker, psychiatrist, counseling psychiatrist . . .

A Yes. I would say in general they were all health professionals. Now, it depends on your specific definition . . .

Q We're using it in the broad . . .

A In the broad sense of the word, that is true, yes.

Q Are there ever—at that staffing stage, are there ever any outside individuals involved, such as a teacher, member from the community, someone along those lines?

A No, not at this particular staffing. Now we—the one thing we will do is that we would—we sometimes encourage parents to be at the particular staffing, and as far as the teacher or this kind of thing, we hope that we've made every effort to gather some of this kind of information prior to the staffing. But as far as I know, there have never been any of these kinds of people at the staffing itself. I would say again, that I would find no objection whatsoever to a non-mental health professional being present at the staffing.

Q The . . .

A We do have, at the staffing one person that was left out. Each—we have a system for patient's rights and this kind of thing, and each building has a particular employee whose—has the primary job—and at staffings, if you'll look under patient's rights and stuff in the policy manual . . .

Q Right, which is part of Exhibit Two.

[25]

A Yeah. But we—these people are certainly there. One of their approaches is to make sure that this patient, be

he adult or child, it's not different with us, that his rights are protected according to the Georgia Code and this kind of thing regarding patients' rights and policies.

Q I'll show you part of the packet marked as Exhibit Two, at the top of that page, which is labeled patients' right. Would you mind reading that first paragraph, referring to . . .

A "The patient, although a minor, is a citizen of the United States of America and the State of Georgia. He is, therefore, entitled to every right and privilege accorded minor citizens of the country and state as specified under the laws governing the rights of mental patients." Is that what you wanted?

A Right. Who is the person that's assigned to represent or act as—I'm not sure of the term you used—act on behalf of the juvenile or child . . .

A You mean the name of this person?

Q No, not the name, but what is their status within the overall institution, a social worker, a technician, psychiatrist?

A Let me—this will vary. First of all, an individual is assigned, that this is a primary job of the entire hospital, at the present time this happens to be a clinically trained chaplain, and he has this assignment. Now each building—at the time—these change, but at the—each building has—each cottage, a person for that particular cottage to link in to this one person, since he couldn't effectively see through the whole hospital, and at the time these are elected periodically, these people are elected by the patients [26] on the unit. There is an election where the patients select the nurse, the nursing assistant, or this kind of thing . . .

Q Would that include the C.A.A.P.? Or what I refer to as—what we've been referring to as the C.A.A.P.?

A Uh-huh. Uh-huh. (Affirmative.) Right, now I could call and find out—I can't name the particular person there . . .

Q That's all right. That person would be elected by the children on the ward?

A Uh-huh. (Affirmative.)

Q The children—I will use the term children . . .

A Okay.

Q . . . to refer to children and adolescents unless I indicate otherwise.

A And then throughout the building there are large visible signs in each building telling you who the person is from this unit and telling you that, say, Chaplain Stout is for the entire hospital.

Q Okay. And the—in addition to—your patient rights indicate that a violation of those rights will be grounds for dismissal and they involve representation and informed consent among others. Has there ever been any problems with the individual who is acting as the—under this section as a patient advocate, the elected representative in terms of asserting what they regard as the best interest of the child against other staff members within the institution?

A No, I don't think so. There have been many times when these people have, through their process of coming to the Chaplain, made specific complaints or recommendations and brought— [27] Chaplain Stout and this person making this then brings this to our general staff meeting of the hospital, and we have, you know, discussed this

and take corrective action and this kind of thing, but I don't know if there's ever been any problem connected with it or any sort of retribution against an employee or this kind of thing.

Q Would there—is there, to your knowledge, any individual who acts as a patient advocate from outside the institution, who, you know, could work with the individuals already assigned?

A The only people that we know here is the Georgia Legal Aid Society, who has come to our hospital representatives in Augusta, and they have been through the hospital, they are welcome there any time, they have made a film—we have closed circuit audio-visual system throughout our hospital. They have made a film themselves, different from our film, informing patients of their rights, and this film is shown periodically several times each week. They're told how they can get in touch with these people, and this kind of thing.

Q Do you welcome that, or do you see this as . . .

A No, I welcome this. I think the people there at Augusta will tell you we welcome them with open arms.

Q Why would that be?

A Why would that be?

Q Yes.

A Because I'm in favor of it.

Q In favor of having outside representation . . .

A Sure.

Q . . . for the individuals . . .

[28]

A Sure.

Q And that would include children and adolescents?

A Sure.

Q You mentioned that in a certain percentage of cases, approximately ten percent, there is an occasion where the parents will not participate, if I'm correct?

A Uh-huh. (Affirmative.)

Q In those cases, or in any other cases, is the opportunity or the potential for conflicts between the child who is in the institution and the parent, both in terms of either the initial entrance into the institution or the eventual release of the child?

A I'm not quite sure I specifically understand the question. Can you give it to me again?

Q Well, I can try. Could there be a conflict in that the hospital would not desire to release a child or adolescent to the parent because the child—the parent may not be ready to receive the child, although the child would be well enough to be released?

A No, I don't think so. I couldn't see this sort of thing. One of the problems we have sometimes in this case is in getting the parents to take the child back. They, in essence, don't want the child, and they are running from us and our efforts to try to work out a specific family inner-action that's gone on in this respect.

Q Would that same sort of situation that you described, the parents running away, I think is the way you put it . . .

A Uh-huh. (Affirmative.)

[29]

Q . . . be present during the admission process itself?

A No, I don't see how it would be present during the admission process. Very often what has occurred here, is that the child is brought to the hospital sometimes, by the judicial process, through the court systems, and the parents feel like they didn't have any part in the admitting of this child to the hospital and aren't going to have anything to do with it. There are often—is an amount of hostility and antagonism between them and the child which has reached the point where they don't want to accept this child, and the big problem is very often not getting the child well enough to go home, but getting these parents to essentially, you know, even take this child. And on one or two occasions we had to go back into the court or through D.F.C.S. to get a disposition made. There haven't been a lot of these, but they do occur. I don't see any sense—you know, I'm not trying to hide that that sort of thing does occur.

Q Uh-huh. So following up on that, in your last point, what action—maybe you've already stated it, but what action do you take—do you have any recourse if the parent does not want the child or is running away . . .

A Generally speaking, in this case, we would link in with the D.F.C.S. worker as far as doing something about this child, to get them out of the hospital, either as far as making a foster home placement of some type with this child, or seeking judicial help to get the parents to take this child or something.

[30]

Q You said two points, let me follow up on each of them, so that I can try to understand both. As to the

seeking of some sort of foster home placement or group home placement, have you had fortunate experiences in being able to locate that kind of placement within a reasonable period of time?

A They ave very tough to locate. I think the thing we're fortunate in is that we've only had to locate one or two out of several hundred admissions. If we had very many to locate, it would be very difficult, because even the one or two we had, it took us some period of several weeks . . .

Q It took you several weeks?

A Yeah, to locate. And remember—as I say, we've had very few of them, so I could see a potential problem there, where if you needed several of them.

Q What would you do—hypothetically, what would you do if it took you more than several weeks, and your treatment plan and your staffing had indicated release?

A Okay, we would have no choice except to keep the kid until we found adequate placement. I know of no other choice that we would have available to us. One particular case, the parents apparently left the state. The kid was placed in the hospital and — I believe by the courts, we can seek out this case—but apparently the parents couldn't be found, and the child was ready to go, and it took several weeks to find—you know, I don't know, three, four, a couple of weeks to find a foster home for this particular child. But I think we have no choice, and of course, we would be as active as possible to find this placement.

[31]

Q If—your second point was that the possibility of

seeking some sort of judicial release to get the parents to take the child back . . .

A I think, and now this is not—I'm not a hundred percent sure, but I think there was one case where, when the D.F.C.S. worker was involved in this thing, it got into the courts that—the court system essentially insisted that the parents take their child back. I believe that there was this one case. It's one of these things two or three years ago, and I think I remember this.

Q Let me ask you this because I am somewhat confused. We're talking about parents that place the child in an institution and then—and I realize we're talking about a limited number according to your figures—that do this, but then do not want the child back, to try to avoid . . . parental responsibilities, is that correct?

A Uh-huh. (Affirmative.)

Q Then do you feel that those same individuals, at the time of placement for the child, are desirous to have the child placed in an institution for the same reasons—for the same basic feelings that they don't want the child back after he or she has been there for a while?

A Sure, I would say that that's probably true, but let me say this, we're not going to admit the child to start with unless the admission of the child to the hospital seems in the child's best interest at the time. Now we have a lot of parents who bring the children to us wanting to place the child in the hospital for which we, you know, do not place [32] the child in the hospital but say to the parents, "We will work with you on an out-patient basis to resolve this problem."

Q Okay. And that—those decision—well, the process by which those decisions are made are done through your

criteria, there have been—these policies and procedures that are marked as Exhibit Two?

A But the essential criteria for ever placing a child in the hospital is that the child needs hospitalization. Now one could debate forever this particular criteria. I'm sure you know that, but nevertheless, the criteria is based upon the concept that the child needs to be in the hospital, not that the parents want to get rid of him.

Q But you have developed, essentially, a process through your policies and procedures, to assure that that decision—the objective of your policies and procedures is an attempt to assure than when that decision is made, it is a valid one . . .

A Right.

Q . . . that's why you have set up these policies and procedures?

A Right.

Q Now, are you aware of any similar policies and procedures of this nature done on a state-wide basis?

A No, I can't answer that, because, you know, I know of no general disbursal of information or of each place policy manual and this kind of thing—each facility has, as far as I know, a lot of these in here, but I can only speak for how we do it and not how it's done in other places.

Q And the policies and criteria that we have in Exhibit Two, were these drawn up pursuant to a directive that you received, [33] or did you do them basically on your own initiative?

A No, they are drawn up pursuant to the fact that any hospital has to have a set of policies and procedures

to operate under, and we, of course, are accredited by the Joint Commission for Hospitals, and they specifically require—and each time we have a Joint Commission survey, they go over these things, you know, spend days reading each page and this sort of thing.

Q But—okay. And these policies and procedures that you've adopted and that are written up and placed into operation, could be changed by you as—as the administrator of the Regional Hospital, is that correct?

A No. They—not specifically. Certain policies, for instance, the utilization review has to be changed by the utilization review committee.

Q No, but I'm talking solely about Exhibit Two.

A The Executive Committee of a hospital would change . . .

Q Would do this?

A Right. I don't—I cannot—a superintendent can't change policies by simply administrative action. He would certainly call a meeting and explain why he felt like they should be changed, but there are appropriate committees regarding all types of policies. You've got a policy, for instance, for control of infections in a hospital. If you're going to change something there, you've got to get the Infections Control Committee. This approach is required by the Joint Commission, by the way, for someone to be able—for a hospital to be accredited, this approach.

Q Which approach?

[34]

A The approach of having specific committees set out for particular types of policies and this kind of thing.

Q One of the things, in looking at Exhibit One-A, if I understand Exhibit One-A correctly, this chart—bar graph, indicates the total number of—well, the number of patients and the longest length of stay for a year period, is that correct? Or a twelve month period, I guess I should say, the fiscal year '74-'75.

A For a twelve month period, right.

Q And the longest time that any one child remained in the C.A.A.P. was two hundred and fifty-one to two hundred and fifty-six?

A That's right.

Q And then there's . . .

A And that covers that three hundred and sixty-five day period.

Q Right. And then there's a significant gap and it goes down to one hundred and seventy-six to a hundred and eighty days . . .

A Right.

Q . . . the bulk of which, I think you indicated here, and I'll assume this is correct for the time being, that fifty percent of the patients are discharged by day thirty?

A Right, that's correct.

Q Have you ever had occasion or do you know of, within your institution, for a child or adolescent to remain hospitalized beyond the two hundred and fifty-six day period?

A No. To the best of my knowledge, no. I would have to check this information specifically, will be glad to do it, but to the best of my knowledge that is the longest stay that a child [35] has ever had.

Q Based on that data, and assuming that you're correct, would you assume—why would that be?

A Why would what be?

Q Why would a child remain—most of the children remain in the institution for a limited period of thirty days, and a child remain there no more—for a year period, than two hundred and fifty-six—two hundred and fifty-one to two hundred and fifty-six days?

A Are you asking why, for instance, a child would remain this long period . . .

Q No, not why they would remain that long, but why wouldn't they remain there any longer than that?

A Well, that's simply the longest one that we have had to date since we opened the hospital in terms of severely disturbed children.

Q Would it be possible—I guess what I'm trying to get at, probably in too indirect a way—would it be possible for children to remain in your institution longer than that . . .

A Yes. Yes, it would be possible.

Q It would be possible?

A Yes. It is quite conceivable that we may get a very disturbed autistic schizophrenic child that could stay longer. All I can say is that we haven't had one. We have been able to get them out within this period of time, but I cannot tell you that it's—you know, wouldn't be possible. I think obviously a general statement is that the better the program [36] the shorter period of time people stay, but there is an occasional child who is extremely disturbed that must remain in an institution. There are a very small number of these, but they do exist. We have not picked up and hospitalized one of them.

Q This would be the exception, then, rather than the . . .

A Yes, and there is a small number of these kids. It should be a very small number of them.

Q Would you agree with the statement that, I believe, one of the individuals whom we have deposed over the past few days, said that it would be—that there would be a great deal of review and question if a child remained in an institution beyond a three month period?

A Well, certainly there would be a great deal of review. Beyond this three month period, there would be a constant review as to what could be done or why this child was remaining there.

Q Why would that be, in your opinion?

A Because it should be very rare for a child to have to be there. This is not saying that it cannot occur, or there will not be examples, but it should be rare enough that past this period of time there should be very close scrutiny of any and all cases where this occurs, the reasons being very specific.

Q And indicated in the record of that individual?

A Absolutely. Actually, a part of his on-going treatment plan, is an on-going process, as to, you know.

Q Talking about your on-going treatment plan, is that when—if I understood you correctly, you indicated that when the individual first comes into the institution or shortly thereafter, [37] this treatment plan is devised, is that correct?

A Right.

Q And as part of that plan, there's a—it aims at both treatment within the institution and . . .

A And release plans.

Q . . . and release plans.

A Exactly. And it's reviewed and modified weekly depending upon justification, what's going on with the kid.

Q And the family is made a part of this review at certain stages, depending on the case . . .

A The family is also seen weekly.

Q Okay, that's where I may have misunderstood you. The family is seen weekly by individuals within the institution?

A Right.

Q As part of the overall treatment plan for the individual?

A Exactly, working with the family, and also to keep the family much involved, to keep the family appraised of the situation, and to work with the family on problems which may be found in working with the child during the week.

Q Okay. In the beginning of your direct examination you indicated the number of staff that you have at the insti—at the C.A.A.P. portion of the institution. About how many cases would the chief psychiatrist of that C.A.A.P. have, the person that—I think it's Doctor Wood?

A No, Doctor Wood is the Ph.D. psychologist who is the director of all of our children's programs.

Q Oh, okay.

A Doctor Clark is the psychiatrist. He is the person primarily [38] responsible, the primary physician, psychi-

atrist for the twenty-some in-patients plus he is seeing out-patients. We have three part-time psychiatrists, one of which is a child—certified child psychiatrist. They are there for staffings, for review of the evaluation, this kind of thing, but they also have selected children and specific treatment programs.

Q What would Doctor—would Doctor Clark's patient —I use the term case load—the number of patients that he is responsible for, sees on a regular basis and treats as their psychiatrist, would that be limited to the twenty-some children and adolescents or would he — his out-patient case load—he has an out-patient case load?

A Yes.

Q About how many people would he be seeing on an out-patient basis?

A He is primarily involved in the evaluation status of the patient initially and any medication checks which come up. The patients who are being followed as out-patients, the psychiatrist who is involved or supervises these, these are usually the part-time psychiatrists which we have on our staff. I shouldn't add something, but I want to add this because I'm not sure it's written down there, but it is our policy and probably should be written down. All children who are admitted to our hospital, where this is at all feasible for the condition of the child, conditions, etcetera, we try to operate the hospital where that when we work with these kids on an in-patient basis five days a week and have them home for the weekends, and then have the parents—we then have a Sunday evening [39] session when the parents bring them back to see how the weekend goes, and approximately two-thirds of all of our kids are home with their parents for the weekends.

Q Okay. We have here, and you've been describing basically the way your institution operates, and that method of operation is set out in some detail in your policies and procedures, would you find it unduly burdensome or do you think it would be inappropriate to devise similar policies and procedures on a state-wide level?

A Oh, I don't think so. I guess I would have to say that similar policies, I think, in general should exist on a state-wide level, but we must keep in mind that there are some differences in the availability of community resources and other things throughout our state, and I think this has some bearing. Remember that we have what I think is a very adequate community center there to evaluate these children in general prior to admission.

NOTE: (Brief off the record.)

Q We were talking about your policies and regulations and we had spoken about the feasibility of doing this on a state — requiring this on a state-wide level. Do you think, as an administrator of a regional hospital, and one that has written policies and regulations, of the—that it would be feasible or practical to run a hospital your size or larger without detailed policies and procedures such as these?

A No, I think you have to have detailed policies and procedures to run the hospital, and I think that these have to specifically be detailed for the hospital in accordance with that particular [40] hospital.

Q And in writing?

A Absolutely and in writing. And widely disseminated with copies readily available, and with some guidance and follow-up that the staff know what these policies are.

Q So that they can be implemented?

A I can speak specifically about the C.A.A.P. unit since I asked the question. I'm going to do it for the rest of the hospital later. But these policies and procedures, Doctor Wood goes over these with staff members periodically and with all new staff members that come on board in that program. There is a routine going over with these people of the unit's policies and procedures.

Q The—one final question, the state statute that we're speaking of in this particular case of—simply allows a hospital to accept a juvenile, a child or adolescent, upon the request of the parent or guardian, is that correct? Are you familiar with that statute—generally familiar?

A Yes, it allows the hospitals to accept the patient.

Q Okay. And your regulations and procedures assure that that individual can be accepted only under certain circumstances?

A It can be accepted only under the circumstances that we feel he needs to be admitted, and there are occurrences, and we can bring bar graphs in forever, where an admission may take place at night or something like this when there's no way that you can have adequate staff to ensure this, but the kid goes home the next day, because he then goes through the evaluation [41] process and we, you know, get the kid out of the hospital.

Q That will do it.

END OF DEPOSITION

* * * * *

[1]

EXHIBIT 2

CHILDREN AND ADOLESCENT PROGRAM PLAN OF SERVICES

May, 1974 Revised

The goal of this program is to meet the mental health needs of children and adolescents, their parents or parent surrogates in this facility's 13-county catchment area where indicated through the use of public facilities and state funds. In the practice of short-term procedures, this usually involves the evaluation and treatment of children and adolescents considered emotionally or behaviorally disturbed. Long-term goals involve enhancing the general adjustment and mental health of the target population through the use of the briefest, least expensive, most indirect, and least restrictive intervention possible (e.g., therapeutic summer camp).

Psychiatric, psychological, social work and academic evaluations are available either through the Georgia Regional Hospital at Augusta or the Augusta Area Mental Health Center. The Regional Hospital is a 24-hour-a-day in-patient facility. The Mental Health Center is an out-patient clinic which currently operates from 8:30 a.m. to 5:00 p.m. Monday through Friday. Therapeutic services are also provided through both of these facilities.

Application for in-patient evaluation or treatment is made through the Regional Hospital's Clinical Director's Office for initial screening. This office may make referral to the Mental Health Center if the evaluation and/or treatment may be more legitimately carried out on an out-patient basis. Direct application for evaluation and/or treatment may be made to the Mental Health Center. At any point in the course of evaluation or treatment, refer-

rals may be made to the Regional Hospital's Clinical Director for any needed in-patient management.

This program offers in-patient care, milieu therapy, therapeutic education, partial hospitalization, day care, aftercare, and out-patient services. The major therapeutic modalities available include psychoactive medication, individual psychotherapy, group psychotherapy, activity therapy, parental counseling and behavior modification. Initial contact with adolescents and their families is outlined in the program's "policies and procedures".

Each patient is given a psychiatric, psychological and social work evaluation. All in-patients and, when indicated, out-patients receive an academic evaluation. No more than ten days following their completion, the results of these evaluations are pooled at a multidisciplinary staff meeting led by the team physician. At this time a treatment program with specific therapeutic goals is formulated. This treatment plan becomes a part of the patient's permanent medical record. Also, at this time, a date is set for review of the treatment plan. The frequency of review and time interval between reviews is set by hospital policy. At these reviews, the tentative discharge date, which was set at the initial staff meeting, is either confirmed or a new discharge date is set. This decision is based upon the patient's progress [2] and the extent to which the goals of the treatment plan have been met. The patient's status with respect to the planned discharge is discussed with the patient and his or her family.

The Children and Adolescent Program is a "unified" program in the sense that its director has responsibility and authority for all phases of the program. The director

also maintains direct or indirect supervision of all personnel in all phases of the program. These phases include the in-patient facility, any day care or partial hospitalization, the therapeutic education program, and the out-patient and after care facilities. This provides for a free flow of communication among the staff of the various phases. Continuity of care is also enhanced for patients who may flow through various phases of the program.

Parental or parent surrogate involvement is encouraged throughout the patient's evaluation or treatment process. In some instances, individual parental counseling sessions are scheduled. Weekly group therapy sessions for all parents are scheduled. A monthly parent conference is held for more didactic presentations. Periodic parent-teacher conferences are held in the therapeutic education phase of the program. Several "special events" are scheduled throughout the year for mutual participation by patients and parents. Weekly "social hours" are scheduled in the in-patient facility upon return of patients from weekend passes. Structured play activities are provided at the out-patient facility for siblings of patients and this is scheduled at the times during which patients and parents are in therapy sessions.

Various other services are also available to patients. Dental services are available through a full time dentist employed by the Regional Hospital. Minor medical and surgical procedures can also be performed by this facility. Any other indicated, more extensive medical-surgical or dental procedures and any special assessments are available through various other facilities in the area by contractual arrangement via the office of the Superintendent

at the Regional Hospital. Emergency admission to the in-patient facility is available on a 24-hour basis (see procedure and policy). Aftercare is available to in-patients at the Augusta Area Mental Health Center, its satellite clinics and various satellite clinics of the Regional Hospital.

From time to time various staff members of the Children and Adolescent Program serve on advisory boards and task forces for other community agencies. The program also provides practicum experience for students from other community agencies. Examples of agencies involved include the Medical College of Georgia, Augusta College, Augusta Area Technical School, Veterans Administration Hospital. Examples of types of students involved include nursing students, education students, child development technicians, undergraduate psychology majors and psychology interns.

[3]

The Children and Adolescent Program maintains liason with school systems, Department of Family and Children Service, and Court Service Workers in a 13-county catchment area. Liason is also maintained with the Regional Youth Development Center which serves approximately the same 13 counties and with the state Youth Development Center located in Richmond County. The team's social workers maintain communication regarding the patient's current status, progress and the plans for future treatment and discharge with all these agencies excepting school systems. In the latter case, liason is maintained by the program's Child Development Technician. Application for admission to the in-patient facility for evaluation

or treatment is made to the Office of the Clinical Director at the Regional Hospital. Arrangement for out-patient evaluation or treatment is made through the office of the Director of the Children and Adolescent Program.

This facility is organized along the lines which have featured both a department/services sytem and a team system. Administratively, lines are along a department/service basis. Clinically, program personnel function as a team. General clinical guidelines are established by the program director in consultation with the heads of the departments of the various services represented in the program. Specific clinical therapeutic decisions and practices are carried out by two treatment teams, one for Children and for adolescents. Each of these teams is led by different psychiatrists (see "policy and procedure").

The roles and responsibilities of staff members in meeting the program's goals and objectives are delineated elsewhere in "policies and procedures".

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

CHILDREN AND ADOLESCENT PROGRAM

ADMISSION TO PROGRAM

June, 1973

In-Patient:

A. Scheduled:

1. Upon ascertaining the need for admission, the Clinical Director's Office will assign a bed and a date for admission. On the date scheduled for admission, the patient will report to the Medical Record Department where he will be formally admitted to the facility.
2. Medical Records will notify the unit clerk or charge nurse of the patient's arrival and readiness to report to the unit.
3. The unit clerk or charge nurse will notify the physician, Social Worker, and unit staff of the patient's presence in Medical Records and will assign an appropriate staff member to attend the patient and his family.
4. A staff member from Medical Records will escort the patient to the unit, or, when necessary, the charge nurse will send an appropriate staff member, keeping in mind that this interaction is the first formal contact with the unit personnel.
5. Upon the patient's arrival on the unit, the physician, Social Worker, and staff will be notified of the patient's arrival.
   a. The physician will admit the patient to the unit, writing the tentative treatment plan and appropriate orders.
   b. The Social Worker will interview the family or representative explaining the program to them and answering any questions they may have at the time.

   c. The unit clerk or charge nurse will see that appropriate forms are signed, that all clothing and valuables are appropriately handled, and that the patient is searched prior to admission to the living quarters. The unit clerk also notifies the school and the Food Service Department of the patient's admission on the unit and schedules routine lab work and X-rays.

[2]

B. Emergency:

1. If a patient is admitted to the unit as an emergency admission during regular working hours, he will report directly to the Medical Record Department. The Clinical Director will determine whether this is a warranted emergency admission. If so, the patient will be admitted by the Medical Record Department and the same procedure will be followed as for a scheduled admission. If a patient needs emergency admission after working hours, the physician on duty will make the determination for admission and the patient will report directly to the unit. The following day, the patient will report to the Medical Record Department for admission and the same procedure will be followed as for a scheduled admission.

C. Evaluation:

1. A patient may be admitted to this facility by request from the Juvenile Court for an evaluation of his mental status. The patient will follow the same routing procedure, however, he will be admitted for five days during which time he will receive psychological testing, academic testing, psychiatric evaluation, social work evaluation and any other evaluation deemed necessary. This information will be forwarded to the Court by the Medical Record

Department at the end of the five days and a recommendation will be made as to whether this patient needs further hospitalization and treatment. If so, he will remain in the hospital. If not, the patient will be released to the Court.

D. Without Parental Consent:

1. An adolescent patient may be admitted to the hospital without consent or knowledge of the parents. The same procedure will be followed for this admission as for a scheduled admission. The patient will be encouraged to tell the staff any information necessary for treatment such as the names of his parents and why he wants this information withheld from them. His refusal to give this information, however, will not prevent him from being admitted to the unit.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

/lp

CHILDREN AND ADOLESCENT PROGRAM

PHILOSOPHY

CAAP, with the sun as its symbol, is designed as an "intensive treatment program" in which major emphasis is placed on accurate diagnosis, realistic treatment goals, and the idea that all experience is a learning experience. Consequently, the program staff seeks to maximize experiences which may have a positive impact on the child or adolescent and his family through formalized therapy or therapeutic interactions stemming from healthy exchanges which occur in the course of participation in the program's activity oriented milieu.

Committed to a multi-disciplinary approach, the staff recognizes and respects the contributions each discipline has to offer, and operates as a "team".

Since the team concept is also extended to include the patient's family and community, the staff encourages active participation by relatives and community agencies in working toward a healthy adjustment for the child or adolescent participating in the program.

Further, the staff, aware of the impact of behavior on others, attempts to serve as models for the patient and his family.

/s/ DOROTHY Z. WOOD, Ph.D.
DOROTHY Z. WOOD, Ph.D., Director
Children and Adolescent Program

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CHILDREN AND ADOLESCENT PROGRAM

PATIENT RIGHTS

The patient, although a minor, is a citizen of the United States of America and the State of Georgia. He is, therefore, entitled to every right and privilege accorded minor citizens of the country and state as specified under the law governing the rights of mental patients.

Primary rights, to be protected at all times by the staff; the violation of which may be grounds for dismissal, are:

1. Confidentiality
2. Representation
3. Informed Consent
4. Communication and Visitation
5. Protection of Person and Property

CONFIDENTIALITY

A. Release of Information

1. Written

   A written release of information form must be signed by the patient's parents or representatives before any information may be released to anyone other than a sister state institution. Medical Records releases all written information with the exception of the school's academic report which is sent from the Academic Supervisor's Office.

2. Verbal

   Only authorized program staff may release verbal information concerning a patient to other than the patient's family. Authorized staff are:

   1. Unit Director
   2. Psychiatrist
   3. Social Worker
   4. Psychologist
   5. Charge Nurse

Patient Rights

6. Child Development Technician (as it applies to school placement or plans)
7. Academic Supervisor (as it applies to school placement or plans)
8. School Nurse (only for physical reasons)

[2]

Under no circumstances may any other program staff member in any way communicate any information concerning a patient or his family unless he has been specifically authorized to do so.

REPRESENTATION

It is the responsibility of the program Social Worker to serve as the agent for the patient and/or his family whenever a violation of a right may be questioned as outlined under hospital policy.

Further, at the time of admission:

1. The unit clerk will review with the patient's parents or representatives the patient's rights. She will, also, answer any questions they may have concerning program policies governing:

   1. correspondence and communication
   2. Visitation hours
   3. Valuables

INFORMED CONSENT

Insofar as possible, the patient and his family should be informed about his treatment, medication, and progress. This is the primary responsibility of the physician but may be delegated.

No research which involves the patient directly will be conducted without his or his parent's or representative's consent which shall only be requested after a full

Patient Rights

and complete explanation of the nature of the research, and future use of the information obtained.

All research must be approved by the hospital Research Committee before it can be initiated.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

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CHILDREN AND ADOLESCENT PROGRAM
TREATMENT PLAN

October, 1974

A. Admission

Diagnostic and Treatment Conference:

The importance of this conference cannot be overstated since it is the heart of the Children and Adolescent Program. Consequently, all staff who attend should make every effort to be prompt and prepared to contribute in their area of expertise.

All patients admitted to the program Monday through Friday will be staffed the following week at the appropriate conference.

Children	Wednesday, 3:30
Adolescents	Thursday, 3:30

B. Review Diagnostic and Treatment Conference:

At the admission Diagnostic and Treatment Conference, a tentative discharge date is set. One week prior to this date, a full staff review of the patient's progress is conducted and the discharge date is confirmed or a new tentative discharge date set.

Routine progress reviews are conducted weekly. Review staff conferences are held

Children	Wednesday, 3:00
Adolescents	Thursday, 3:00

C. Conference Staff Composition and Roles:

a. Psychiatrist

As conference leader, the psychiatrist pulls from the data a coherent picture of the patient, his family and their problems, establishes a working diagnosis, decides on the treatment modalities, sets a tentative discharge date, and either interprets these to the patient or designates the responsibility.

b. Social Worker

The Social Worker has responsibility for a comprehensive social history. She also functions as a liason between the program staff and any community agency staff involved with the patient, inviting them to the conference if indicated, etc. In cooperation with the psychiatrist and staff, the Social Worker interprets the conference findings to the patient's family.

[2]

c. Psychologist-Ph.D., Psychological Technician

Responsibility for administering, scoring and interpreting in writing all tests of a psychological nature is shared by the Ph.D. and technician. Results of testing are presented at the diagnostic staff conference by the technician.

d. Child Development Technician

Responsibility for administering, scoring, and interpreting in writing results of all academic tests as well as the presentation of these results at the diagnostic conference. The Child Development Technician also functions as secretary for the conference, taking minutes for the patient's charts and helping the physician fill out the treatment plan.

e. Nurses

Nursing and/or behavioral observations such as peer interactions, family interactions, etc. observed on the unit are reported by a member of nursing supervision. Individual nursing treatment care plans are drawn from this staff conference, as well.

f. Teachers

Reporting behavioral observations of classroom interactions, assessment of interest level, study skills, are the responsibility of the teaching staff who is working with the patient's age group.

g. Activities

A gym representative reports behavioral observations of patient's during gym activities.

h. Chaplaincy

Chaplain intern assigned to program reports on Ethics class behavior when appropriate.

i. Dietician

Consults on special diets for patients with physical health problems. Attends staff by invitation of the Head Nurse of her delegate.

j. Psychiatric Consultants

Help in the provision of quality care through aiding in accurate diagnosis, realistic treatment plans and assumption of individual and family therapy as time permits.

[3]

k. Visitors

Other agency staff are invited in order to promote maximum two-way communication at diagnostic conference and treatment conference. The primary purpose of a visitor's presence is to assure continuity of care.

l. Therapists

Staff who function as therapists are expected to attend the review staff to report on the patient's progress in therapy.

m. Speech Pathologist

Responsible for administering speech and language evaluations. Presents results of these tests at diagnostic staff conference.

/s/ DOROTHY Z. WOOD

DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

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CHILDREN AND ADOLESCENT PROGRAM
TREATMENT PLAN

October, 1974

I. Definition:

The treatment plan is a formalized statement of therapeutic goals and the methods proposed to reach these goals. They are characterized as short, intermediate and long term and are set by the psychiatrist and staff at the time of the initial Diagnostic and Treatment Conference.

A revised treatment plan is the result of review and modification of the previous treatment goals.

II. Definition of Terms used in Treatment Plan:

1. Diagnostic Interview:

Done by an M.D. or Physician's Assistant and countersigned by M.D. The parameters of this interview are:

a. Chief Complaint
b. Present Illness
c. Family History
d. Personal History
e. Mental Examination
f. Physical Examination
g. Clinical Neurological Examination
h. Diagnosis: Mental and Physical
i. Treatment Plan
j. Prognosis

2. Observation of Patient:

Noting and recognizing in the patient's medical record facts or occurances that involve the individual patient. These observations are made by nursing and teaching staff as well as other members of the clinical team.

[2]

3. Formal Testing:

A routine battery administered by Psychology staff to include psychological and academic evaluations.

4. Social Work Evaluation:

An assessment of social situation of the patient and his family resulting in a social diagnosis and social plan of care.

5. In-Facility Privileges:

The patient is permitted access to all special therapies facilities on campus (i.e., gym, library) and is allowed to participate in hospital-wide events which are appropriate to the patient's age and diagnosis. In addition, the patient is allowed to utilize the facility's grounds, athletic fields, and picnic areas for recreation or leisure.

In CAAP, all patients are always accompanied by a staff member except when being visited by parents or other authorized visitors.

6. Special Diet:

As prescribed by the physician. Example: bland, 1800 calorie, salt free, Diabetic, etc.

7. Group Therapy:

A programmatic weekly session of age appropriate group interactions led by a therapist and co-therapist. Emphasis is on group intervention to solve individual problems.

8. Special Education Services:

Assignment to an educational curriculum suited to the patient's academic, social and psychological

functioning and needs. This assignment is based on the patient's academic history, the results of academic evaluation, and the findings and recommendations presented at the Diagnostic and Treatment Conference. These services are provided in an educational facility housed separately from the patient's living quarters. The special education program and its staff are under the administration of the Director of the Children and Adolescent Program.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

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CHILDREN AND ADOLESCENT PROGRAM

NURSING CARE PLAN

June, 1973

A nursing care plan is a set of written, specific, and concrete goals drawn from treatment goals.

Emphasis should be placed on describing in writing behaviors or attitudes to be exhibited by the staff toward the patient which will aid the patient to reach the goals set for him by the treatment plan. For example: the treatment plan may have as a goal self-esteem enhancement. The nursing care plan might follow through on the goal of self-esteem enhancement by requiring the staff to help the patient to improve his appearance or by requiring the staff to actively praise the patient for small accomplishments.

I. Formulation:

The nursing care plan is intended primarily for nursing staff use, therefore, it is the responsibility of the Head Nurse or her delegate to formulate the plan.

The plan is to be written within the first 24 hours following the initial Diagnostic and Treatment Conference or Review Diagnostic and Treatment Conference.

II. Format for Nursing Care Plan:

A. Describe consisely and accurately

1. Patient behavior or attitude that is to be exhibited for each goal.
   a. short term goal
   b. long term goal
2. Staff behavior or attitude that is to be exhibited for each goal.

3. List when indicated
   a. special staff involvement (one-to-one, particular shift only, etc.)
   b. frequency and time of staff behavior

[2]

III. Implementation

A. It is the responsibility of the charge nurse to be aware of the nursing care plan and of any changes or revisions in it.

B. It is also the responsibility of the charge nurse to see that the nursing assistants are fully informed and understand the rationale for the plan and that they adhere to it.

IV. Evaluation of Nursing Care Plan

A. Charting

1. At least once per week, the charge nurse charts the patient's progress as it relates to:
   a. nursing care plan goals
   b. treatment plan goals
2. The progress report should be a reflection of staff assessment made during patient care conference.

B. Revisions of Nursing Care Plan

Revisions in plan should be made as a result of

1. Changes in treatment plan
2. Assessment at nursing care conference that staff approach has not produced the desired results.

/s/ MAMIE R. HAMMOCK
MAMIE HAMMOCK, R.N.
Head Nurse

/lp

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CHILDREN AND ADOLESCENT PROGRAM
PARTIAL HOSPITALIZATION — DAY CARE

Revised June, 1974

A. Partial Hospitalization

I. CAAP Patient

An in-patient whom the staff considers appropriate for the day care program is formally released to that program after staff review and communication with the patient's parents or representatives.

On the day of transfer:

1. The physician writes appropriate orders releasing the patient to day care status as well as a discharge summary.
2. The unit clerk notifies the Medical Record Department, the Academic Supervisor, and the Child Development Technician of a change in status and the Medical Record Department prepares a chart which is maintained on the unit.
3. The Child Development Technician meets with the patient and his parents or representative to discuss school policies and procedures as they relate to day care.

II. In-Patient—Other Hospital Units

Staff from other hospital units may release patients to day care status after consultation with CAAP staff.

On the day of release:

1. The physician writes appropriate orders releasing the patient to day care status as well as a discharge summary.
2. The referring unit notifies Medical Records and the CAAP unit clerk.

3. The unit clerk notifies the Academic Supervisor and the Child Development Technician of a change in status and the Medical Record Department prepares a chart which is maintained on the CAAP unit.

4. The Child Development Technician meets with the patient and his parents or representatives to discuss school policies and procedures as they relate to day care.

[2]

B. Day Care

Patients psychiatrically in need of a day care program may be admitted directly to that program through the Clinical Director's Office after consultation with the CAAP staff and assure availability of space.

The admission procedure is the same as that for scheduled in-patient admissions with the exception that a bed is not assigned.

/s/ D. Z. Wood
Dorothy Z. Wood, Ph.D.
Unit Director, Non-Medical

/lp

[1] CHILDREN AND ADOLESCENT PROGRAM

COMMUNICATION AND VISITATION

While every effort should be made to encourage free and open communication between the patient and his family within the framework of the program and the laws governing patient rights. Visits to the patient are to be restricted to visiting hours except for family emergencies and clergy who may wish different time arrangements.

I. Visiting Hours:

A. Insofar as possible no activity should take priority over family visits during these hours.

B. The family should be treated courteously — as welcome guests and should not be forced to wait undue lengths of time after arrival before being allowed to see the patient.

C. The right to privacy should be respected during visiting hours, space and seats provided, walks around the campus encouraged, and the staff available but out of ear shot.

II. Visitation Privileges:

Since the patient is a minor, the staff must be sensitive to, and aware of, any legal ramifications resulting from guardianships or court appointed custody.

A. Adults wishing to visit the patient other than legal parents/guardians or caseworkers must be accompanied by the legal representatives or have written visitation permission.

B. Clergy who wish to visit the patient at times other than visiting hours may do so by contacting the hospital Chaplaincy Service and making proper arrangements.

III. Communication—Verbal and Written:

A. Telephone

A public telephone is available for patient use and time must be provided daily for its use.

[2]

1. If the patient has the proper number of points needed to make a telephone call, the staff must allow the patient the use of the phone during telephone time.
2. If the patient is indigent, but has the points, money from the patient fund is to be provided.
3. As with visiting, the right to privacy must be maintained. The staff must remain available but out of ear shot.

B. Mail

Mail should be delivered to the patient the same day it arrives.

Letters:

1. The unit clerk will give unopened letters for the patient to the charge nurse.
2. The charge nurse will give the letter to the patient personally.
3. Should the charge nurse suspect contraband, may insist that the letter be opened and searched in her presence. No attempt to read the letter should be made, however.

Packages:

1. The unit clerk will give unopened packages for the patient to the charge nurse.
2. The charge nurse will give the unopened package to the patient and remain present while it is opened.

3. Items which the patient may not have in his room, such as glass, should be taken from him immediately with:
   a. A full and complete explanation.
   b. Reassurance that it will be returned intact when he leaves.
   c. A clear statement as to where it will be kept.
   d. An entry on the chart.

[3]

C. Personal Property

Since it is the nature of childhood not to fully understand the concepts of personal property, the staff must be diligent in guarding a patient's property for him by:

1. Protecting him from others who might wish to take items which are rightfully his.
2. Providing storage space that is his alone.
3. Helping him to remember to return items (a sweater from the cafeteria, a swimsuit from the pool, etc.).
4. Making clear to him when items are given to him permanently (Christmas presents, etc.).
5. Reporting to parents through proper channels of communication when items have been lost or destroyed and how this happened.

D. Personal Protection

Any form of physical or mental abuse of a patient by a staff member is inexcusable and must be reported at once to the immediate supervisor. Not to do so will be viewed as aiding in the abuse.

[3]

Communication and Visitation

At those times when a patient must be physically restrained, it must be done with the proper holding technique. Quite simply—slapping, pinching, hair pulling, verbally threatening the patient in order to control him, is a firing offense.

Mechanical restraints and/or seclusion are never to be used as a means of discipline. The only acceptable reason for ever using mechanical restraints or the seclusion room is the patient is out of control and in danger of hurting himself or others. Medical orders must be written and documentation made each time restraints or seclusion are used.

A full explanation must be given to the patient by a staff member, making it clear that the patient is not being punished.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

CHILDREN AND ADOLESCENT PROGRAM
CRITERIA FOR DISCHARGE

June, 1973

The decision that maximum program benefits has been reached is ultimately determined by the clinical expertise of the psychiatrist with consideration being give to consultation with the treatment team about:

1. the attainment of individualized treatment goals.
2. Such factors as:
   a. availability of foster home placement, if needed.
   b. situational problems within the home,
   c. readiness of community institutions such as school systems or retardation centers to accept and place the patient.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

May 11, 1973

M E M O R A N D U M

TO: All Units

FROM: Dorothy Z. Wood, Ph.D. (/s/ DZW)
Unit Director, Non-Medical

SUBJECT: Patients Released to School Day Care Program from Other Units

To provide optimum medical coverage for the patient's protection and to insure adequate communications regarding disposition of day care students, we would like for the following procedure to be observed.

When a student-patient is staffed and recommendations for day care are made, the Child Development Technician is to be notified.

A statement regarding the date day care begins, the name of the principle therapist, or whether or not the student will be followed by Aftercare and the date of the first appointment should be made.

The Child Development Technician should be contacted, also, for an appointment for the patient's parents to be held on the date of release to day care in order to discuss day care and school policies and procedures.

At the time dispositions are made about the patient regarding academic placement, promotions, or release from the school program, the physician following the student at that time will be contacted to write appropriate orders.

DZW:lp

GEORGIA REGIONAL HOSPITAL AT AUGUSTA
CHILDREN AND ADOLESCENT PROGRAM

June, 1973

PARENT'S QUESTIONAIRE

METHOD: On admission a parent or guardian will be given a booklet containing the questionaire along with permits for seclusion, smoking, off campus, authority to release child, and authorization to release information. This is to be returned to the social worker at the parents' earliest convenience.

RATIONALE: To obtain optimum information regarding developmental milestones of the child or adolescent. To provide the family with information regarding practices and policies of this unit that will affect their child doing his/her stay here.

/s/ Mamie R. Hammock
Mamie R. Hammock, R.N.
Head Nurse

CHILDREN AND ADOLESCENT PROGRAM
PROGRESS NOTES

July, 1973

Progress notes are a method of condensing:

1. Numerous behavior notes, reviews, interviews and conferences into a written declarative statement regarding a patient's progress.
2. These notes should present a flow of ideas consistent with the treatment plan and provide a basis for revision up to diagnosis and including discharge plans.

Method:

Those members of the clinical staff who are actively involved with patients on a therapy level are to write progress notes of their interactions:

1. Physician
2. Nurse
3. Group Therapist
4. Individual Therapist
5. Psychologist
6. Special Therapist
   a. Chaplaincy
   b. Vocational Rehabilitation

Notes should be written at least weekly for the first month and no less than monthly thereafter.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

CHILDREN AND ADOLESCENT PROGRAM
SUPERVISION FOR THERAPY

November, 1974

In order to provide less experienced therapists guidance, instruction and support in their efforts to conduct group and/or individual therapy and to provide top quality patient care, untrained clinical staff must be supervised by a program psychiatrist.

Method:

Only the supervising psychiatrist may excuse a therapist from a supervisory session.

Each therapist must attend the weekly group session led by the psychiatrist in charge of patient care.

Each therapist should use these sessions to discuss therapeutic problems, ask for suggestions and generally comment on the flow of his/her group or individual session.

The psychiatrist gives feedback on quality of therapy, needed changes, recommendations for improvement and suggest literature to review in regard to specific incidents.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

March 12, 1975

GEORGIA REGIONAL HOSPITAL AT AUGUSTA
UTILIZATION REVIEW PLAN

1. Objective: The objective of the Georgia Regional Hospital at Augusta Utilization Review Plan is the maintenance of high quality patient care and improvement in the effective utilization of hospital services.
2. Organization and Composition: The Chairman and members of the Utilization Review Committee shall be appointed yearly by the Superintendent in such a way as to assure broad representation of the medical and other professional staff, with none of the members having a direct financial interest in the hospital. No physician shall have review responsibility for any case in which he (she) was, is, or anticipates being professionally involved. The Committee Chairman will have served at least one year as a member of the Committee prior to being appointment Chairman. As determined by the Committee, some review functions may be delegated to a trained and qualified non-physician (hereafter referred to as the Utilization Coordinator) who is directly responsible to the Committee.
3. Frequency of Meetings: Meetings of the entire Committee will be held at least monthly. More frequent meetings by the entire Committee, subcommittees, or individuals will be held at the discretion of the Chairman of the Committee.
4. Minutes and Reports of the Committee: Minutes and records shall be kept of all activities for which the Committee is responsible. Records shall be maintained to show at least:

Kuglar Defendant's Exhibit Number Four
JMW 12/5/75

a) The number of cases reviewed by the Utilization Coordinator and Committee physicians in each category (preadmission, admission or extended stay), identified by case number.

b) A listing by chart number of cases in which a question has been raised concerning utilization, with the disposition of such cases.

c) The actions of the Committee and administration regarding studies, procedures, recommendations, etc.

All of the above minutes and records will be considered confidential and will be available only to the Committee, the Executive Committee, the fiscal Intermediary, and the State Agency. They will not be available as part of "discovery" or other proceedings associated with litigation.

5. Criteria for Admission and Extended Stay Reviews: Length-of-stay and level-of-care criteria to be used in the evaluation and encouragement of appropriate utilization shall be selected, modified and approved by the Committee, and shall be readily available to all members of the medical staff, whose suggestions will be welcome. These Committee approved Review Criteria shall include admission criteria, recommended extended stay review dates, checklist and narrative descriptions of clinical conditions considered by the Committee to obviously indicate medical necessity for acute hospital care, and guidelines for use by non-physician staff in expediting the day-to-day functions of the Utilization Review Committee. The Committee may also, as its [2] discretion, decide confidentially to review with particular care the cases of certain physicians and/or selected diagnosis or procedures which may tend to be associated with unnecessary

utilization. Such action by the Committee will be kept strictly confidential and definitely does not constitute criticism or censure. The Review Criteria may be modified as necessary by majority vote of the Committee at any time.

6. The Committee will make every reasonable effort to cooperate with the fiscal Intermediary, State Agency and other groups having a legally required interest in assuring appropriate utilization, while consistently upholding the established principles of patient-physician confidentiality and individual privacy.

7. Admission Reviews: Admissions of all Title XVIII and XIX (Medicare and Medicaid) patients and other patients as described elsewhere in this Plan shall be reviewed within one (1) working day of admission except that, as determined by the Committee, cases of certain physicians or with certain diagnosis may be reviewed prior to admission. Using the approved Review Criteria generally available to the Medical Staff, the Utilization Coordinator and/or Committee physician(s) will consider at least the following information in carrying out this "admission review".

a) confidential identification of the patient, eligibility status, and date of admission

b) diagnosis or symptom(s) recorded on admission

c) physician's plan of treatment as described in the admission note and/or orders

d) where appropriate, justification for emergency admission

e) other supporting material, including history, physical, nurses notes, laboratory and x-ray data, etc.

On the basis of the "admission review", using Committee approved Review Criteria, admissions will be

classified as "medically necessary" or as "questionable". If the admission is considered "medically necessary" an initial "extended stay review date" will be assigned. If the admission is "questionable", further review procedures will be carried out, in the order felt most appropriate by the Committee Chairman:

a) Consultation with the attending physician (whose opinion shall be given great weight) will be obtained.

b) Further subcommittee or full Committee consultation may be obtained.

c) If available, optional telephone consultation may be obtained with the fiscal Intermediary, Medical Care Foundation or PSRO.

After such further review, if hospitalization is felt to be "medically necessary" an "extended stay review date" will be assigned by the Committee. However, if after further review, the final determination of the Committee or a subcommittee of at least two physicians is that hospitalization is not medically necessary, the Committee or subcommittee shall give prompt oral and written notification within two (2) working days of admission (or within one (1) working day of application if a preadmission review) to the hospital, attending physician, patient, the patient's next of kin, and (for Medicaid cases), the State Agency. Such notice will state clearly that further stay is not considered medically necessary and therefore is not payable by the program involved. [3] Patients may, of course, elect to be hospitalized at their own expense and a determination of "not medically necessary" by the Committee must not be interpreted as a criticism of the attending physician or as an order for the patient to be discharged. An attending physician may have an adverse decision reviewed by the full Committee, on request.

8. Extended Stay Reviews: In approved psychiatric admissions, the "initial extended stay review date" will be on a day representing the 50th percentile (median) for the length of stay norm for a specific diagnosis as locally determined. The "initial extended stay review date" for psychiatric patients, however, must be scheduled no later than 30 days from admission. All subsequent "extended stay review dates" will occur at intervals of ½ the median length of stay thereafter. For example, for a diagnosis in which the locally determined length of stay norm is 60 days, the initial "extended stay review date" will be on the 30th day or earlier, and if the patient continues to be hospitalized, every 15 days thereafter until discharge.

   Starting 2 working days before the assigned "extended stay review date" a further evaluation of the patient's clinical status, the attending physician's plan for further management, and his reasons for recommending further inpatient stay will be carried out by the Utilization Coordinator and/or Committee physician(s), using the same Review Criteria and consultation alternatives used in the initial review as described in the preceding paragraph (7). If it is clear to the Utilization Coordinator, using the approved Review Criteria, that continued stay is necessary, a future "extended stay review date" will be assigned.

   If a specific medical complication or additional definable medical problem has developed, the appropriate section in the Review Criteria will be used to assign the "extended stay review date". In no case, however, will the Utilization Coordinator assign an "extended stay review date" further than 7 days in the future.

   In cases where the Utilization Coordinator is unsure as to the necessity for continued stay, or the clinical picture is so complex or unusual as to fall outside the approved Review Criteria, the case will be referred for Committee physician review. As a result of this physicians review either an "extended stay review date" will be assigned or the "further review procedure" described in the preceding paragraph will be instituted. If the final determination of the Committee or subcommittee is that continued hospitalization is not medically necessary, the Committee or subcommittee shall give prompt oral and written notification within 2 working days of initiation of the "extended stay review" to the hospital, attending physician, patient, the patient's next of kin, and (for Medicaid cases), the State Agency. Such notice will state clearly that further stay is not considered medically necessary and therefore is not payable by the program involved. Patients may, of course, elect to remain hospitalized at their own expense, and a determination of "not medically necessary" by the Committee must not be interpreted as a criticism of the attending physician or as an order for the patient to be discharged. An attending physician may have an adverse decision reviewed by the full Committee, on request.

9. Medical Care Evaluation Studies: Medical care evaluation studies are done on a regular basis to promote optimum quality of care and efficient economical use of health care resources. Studies will emphasize analysis of patterns-of-[4] practice rather than individual variations. As a result of these studies, recommendations for changes beneficial to patient, staff, hospital and community will be made as appropriate.

Subjects for Medical Care Evaluation studies may be chosen from existing topic list, as a result of the Committee's recognition of suitable subjects, or on request by the Governing Body or Executive Committee. At least one study will be completed within each calendar year, and one will be in progress at all times. The studies (which may be done in conjunction with, or primarily by other hospital committees) will be accomplished by analyzing data such as that obtained from any one or a combination of the following sources:

a) Medical records or other appropriate hospital data;

b) Internal and external organizations which compile statistics, design profiles, and produce other comparative data;

c) By cooperative endeavor with a PSRO, fiscal intermediary, other providers of services, or other appropriate agencies.

The Committee's report of the results of each Medical Care Evaluation study shall include recommendations for changes to improve the quality of care and to promote more effective and efficient use of hospital facilities and services.

10. Reports: Reports of Committee activities and recommendations shall be made at least monthly to the Superintendent and Medical Executive Committee. Whenever appropriate, other reports and recommendations will also be made to individual Clinical Departments, the Superintendent, the Medical Staff and Business Office. Preparation of these reports is to be the responsibility of the Committee Secretary under the overall direction of the Utilization Review Committee Chairman.

11. Administration Response: The hospital administration will study and act upon administrative recommendations by the Committee, and will report such actions to the Committee on a monthly basis. A record of all actions related to Medical Core Evaluation study recommendations will be a part of Committee Minutes.

12. Administrative Assistance: All necessary clerical and support services will be provided to the Committee by the hospital administration on request.

13. Discharge Planning: In order to encourage the most efficient use of available health services and facilities, all necessary assistance shall be provided to the physician in his (her) timely planning for post-hospital care. For this purpose, the hospital will make available to the attending physician current information on all resources available for continued out-of-hospital care and will help the physician make such arrangements in order to assure proper continuity of care after discharge or transfer of the patient. The preparation and availability of this information is to be the responsibility of the Utilization Coordinator.

14. Non-Disciplinary Role of Committee: The Utilization Review Committee has no authority or power to discipline or reprimand any staff member for any alleged violation of any type. Such authority is reserved to the Executive Committee and Governing body.

[5]

15. Effective Date: This Plan becomes effective 30 days from the date of approval by the Medical Staff and replaces all previous Plans and Amendments.

16. The Committee shall carry out reviews of patients other than those admitted under Titles XVIII and

XIX as determined by Agreement among the hospital administration, the Utilization Review Committee, and the involved third parties (if any). Any such agreement shall be approved or rejected by the Medical Staff at their next meeting. The procedures for such reviews will be separately described in Amendment(s) to this Plan only if they differ significantly from the reviews described for Title XVIII and XIX patients.

Approved by Medical Staff on_____

Approved by _____ on _____

Approved by _____ on _____

MD/kf

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

MILLEDGEVILLE, GEORGIA

10:30 P.M. **DECEMBER 5, 1975**

Depositions of ANN ETHERIDGE and NANCY AUTRY, witnesses called by the Plaintiffs for the purpose of discovery and other legal purposes; taken by Lee Ellen McDaniel, Georgia Certified Reporter T-128, at the Powell Building, Central State Hospital, Milledgeville, Georgia, beginning at the time stated above.

APPEARANCES:

For the Plaintiffs: GEORGIA LEGAL SERVICES
653 Second Street
Macon, Georgia 31204
Ms. Nancy Lindbloom, of counsel

Also appearing: Mr. David Goren

[2]

For the Defendants: DEPARTMENT OF LAW
132 Judicial Building
Atlanta, Georgia 30334
Mr. Doug Lackey, of counsel

STIPULATION:

Deposition being called by the Plaintiffs for the purpose of discovery and other legal purposes. All formalities are waived. All objections except as to the form of the ques-

tion will be reserved until December 20, 1975, when they will be filed in writing to the Court. Witness and counsel agree to waive the right of the witness to read and sign the deposition.

ANN ETHERIDGE

witness, first being duly sworn,
testified on

CROSS EXAMINATION

BY MS. LINDBLOOM:

Q Ms. Etheridge, right—am I pronouncing that right?

A Yes.

Q Okay. Ms. Etheridge, have you ever been deposed before—has anyone ever taken your deposition?

A No.

Q Okay, well, we're here to do that today. The questions I'm going to be asking you I'd like you to speak from personal knowledge; if any of the answers that you're going to give to me are based on let's say an answer you've gotten from a superior like someone who's told you something or from a manual or guide-[3]line that you use in your duties, I'd like you to please mention that. Also, we're going to be recording this—the microphone is right there, so I would ask that if you are going to answer a question, please state either yes or no—sometimes the tendency is to nod, etc.

A Okay.

Q The other thing is if any of the questions that I ask you are confusing or you don't understand what I mean, please feel free to stop me and we can go into it, okay?

A Okay.

Q Ms. Etheridge, would you please state your name and your present position?

A Ann Etheridge, and I'm a Caseworker 2 with the Baldwin County Department of Family & Children Services.

Q What is your educational background; that is, any degrees earned? . . .

A I have a Bachelor's Degree from Georgia College.

Q How long have you held your present position?

A It will be nine years in June.

Q Where did you work before you were a caseworker here at Baldwin County?

A This was my first employment after college; before that I had experience in a newspaper office and various . . . I have . . .

Q Go ahead.

A No, that's okay.

[4]

Q When was your first contact with—we can refer to J.L. as Joey throughout this—when was your first contact with Joey?

A What about the last names of the parents—should I use those?

Q Yes.

A My first contact with the child or with this situation?

Q Right.

A Should I start in November?

[4]

MR. LACKEY: She asked you an "or" question and you answered "Right". She said "first contact with the child or with the situation?"

Q When was the case in your capacity as a caseworker —when was the case first brought to your attention?

A In November of 1973.

Q Have you continued to . . . has this case continued on your caseload since that time?

A Yes.

Q And you're presently Joey's caseworker, correct?

A Yes.

Q Can you describe basically—I know you have many duties in a caseworker's position, but could you outline what your duties are and your responsibilities, specifically in regard to Joey's case?

A Well, that's kind of hard to answer because although I [5] have been the caseworker who has taken care of various things that have come up with this child, Joey was never officially on our caseload or opened as a case for quite a while after my contact with him began, but as far as my duties would go, I was the one who talked, who worked with the personnel here at Central State Hospital, who talked with his mother concerning future plans for Joey or the custody situation.

Q When did you first formally adopt him on your caseload—like you mentioned the first contact you had was November of 1973—do you keep a case file on Joey?

A Yes. We have a recording system that goes into Atlanta and this is for statistical purposes, and my first form went in on him in February of 1974.

Q Did you maintain a case file on him after this initial contact you mentioned in November of 1973?

A Yes, I did.

Q Do you have other children, I assume . . . do you carry a caseload in your capacity as a caseworker?

A Yes.

Q Do you have children in that caseload who are in need of foster placement or group home placement, adoption, this type of thing?

A Yes.

Q What would your duties be if a child today were say to be assigned to you, it was your understanding that child would [6] require foster home placement—as you see your duties in your job as a caseworker, what would you be doing for that child in general?

A Well, it would depend on where the child was and his circumstances—children who are in immediate danger, where they are presently living, residing, are the ones who receive first priority for foster care, and we're a small agency and usually when children are in need of . . . come to us in need of foster care . . . I usually follow them from a protective service situation or from . . . a situation that brings us up to a need for foster care; and if we feel like a foster home is needed, we look in our community to see if we have a resource available.

Q Could you describe—you mentioned protective services—what type of situation would to you call for protective services—could you explain that a little bit further?

A Okay—protective services we usually think of in terms of abuse and neglect.

Q To such an extent that the Department would become involved—is that what you're saying?

A Yes. Complaints or reports that are substantiated of abuse and neglect.

Q And that's when in a situation such as that—is that what you were mentioning about the priority—that children such as . . . you were talking about protective services before . . . you mentioned that that would be a priority—children who are [7] in an immediate situation where they were presently residing would get priority, is that correct?

A Protective services is the priority, but when we become involved in a protective service case where abuse or neglect has been substantiated, we work to keep the child in his own home or with relatives before we place a child in a foster home, but you were talking about children who need foster care and when a child . . . when we think about placing children in foster care—those are protective service situations who are in immediate danger are the children who get first priority for foster care.

Q In your efforts to work towards foster home placement for a child, could you describe the procedure that you go through . . . in other words, what your actions would be first you as a caseworker and what your understanding is if you are not successful at a certain point at the first step, other steps that may be taken in order to secure foster home placement for a child?

A Okay. When we feel that a child does need foster care, usually a caseworker, which would be myself, our casework supervisor in a county department, and our director—the director of our county department would be aware that we feel that foster care is needed for this

child. I would discuss this with Ms. Autry, who is my field representative and if she was in agreement that foster care would be the plan for this child, we [8] would first look at our community resources to see if we have a foster home here in the community available for this child.

Q Could I stop you for one minute—you mentioned Ms. Autry—what's her position—what's her role?

A Okay—Ms. Autry is—I said field representative—but she is our Social Service Director.

Q Is she in a sense above . . . like are there many other local Department of Family & Children Services offices that in a sense are below her or for which she has responsibility?

A Yes, she supervises the Baldwin County service staff and six other counties—the service staffs of six other counties.

Q Okay—continue; you were mentioning that you would contact her?

A Okay. Any foster care placement—it's just agency policy that foster care placement go through your field representative, go through your Social Service Director—we usually call them field representatives. I had said that we look for a resource here in the community and if we don't have a foster home available, one that suits this particular child or children, we let Ms. Autry know this and then she will look within her district, which would compose of the six other counties that she supervises. If there is no resource available within this district, she would to to her regional program director, who is Ms. Juanita Black and Ms. Black would know the foster care re-[9]sources available in the region and if none are avail-

able within the region, then we would look statewide for a resource.

Q Could you explain again to the best of your understanding what that contact would be . . . when you say look statewide—after Ms. Black—let's assume that Ms. Black does not find anything in her region—who would the contact be?

A I think what happens is Ms. Black contacts the other region program directors and they, in turn, would contact by, I would probably think a memo, the other Social Services Directors under them—the Social Services Directors would either know the resources available in their counties or would . . .

Q In the process that you've just described—the steps—would you as the caseworker down in the local county level—would you actually, now you've mentioned that you would initiate the contact with Ms. Autry, would you then, in turn, also make the . . . initiate the contact with Ms. Black or do you make the one initial contact with Ms. Autry?

A I would make the contact with Ms. Autry unless it were unusual I would not go to Ms. Black or anybody higher.

Q In other words, after you make that referral, is the responsibility . . . is the primary responsibility as this goes, in other words, as referrals are made up, would you assume then that Ms. Autry would then make the referral to Ms. Black if the situation warranted or would you feel like that the responsibility and initiative was back on your shoulders, still remained [10] with you—do you see what I'm saying?

A I think so—I would, you know, Ms. Autry would

tell me "Well, I'll talk with Ms. Black about this and see if she has anything to offer, see what she has to say" and I would assume that she would do this—I would ask her at some point in time if she has not mentioned it, I would ask her what has happened with this and this situation, but I'm not sure I can answer you explicitly about responsibility because I still say . . .

Q Let me give you an example of this. We were talking about finding resources for foster home placement. Would Ms. Autry in her search with the step going up or would Ms. Black make the contact with potential resources or would, in other words, would they do the contact with other possible resources for foster home placement?

A They would come back to me if there was foster home available in another county, say it had gone all the way and someone was looking statewide; and say there was a foster home available for the child or children for whom we were looking for a resource in North Georgia—in Carroll County—I would be given the name and number of the caseworker and would call that caseworker and talk with them. Copies—telephone conversations would be written in letters and a copy of the letter would be sent to each Social Service Director.

Q If there were possible, in other words, if a foster home was located—a possible foster home—you would expect [11] that the name of the caseworker in the particular county would be referred to you and you would make the contact, is that correct?

A Usually this would be the procedure.

Q Do you use yourself, when you mentioned recruiting in your own county, do you have any policies or

guidelines or regulations, any manual that you use to help you in recruiting foster homes within the county—do you rely on any directive manual or anything like that?

A We have a child welfare manual that lists guidelines for foster homes, things you look for when doing a foster home study.

Q Do you have a copy of that with you today?

A No, I don't. In the back of this manual are several appendixes and there's one that's very helpful in listing the main characteristics that you look for in a foster home. We also had a foster parents manual put out a couple of years ago. This manual is mainly for foster parents, but it's also a good reference—a very good reference for caseworkers, supervisors, and so forth.

Q Give me as specific as possible when you talk about recruiting in your own county—what does that mean, in other words, who would you go see without specific names—the type of people, like what would you do?

A Foster home recruitment?

[12]

Q Right.

A Well, I'll just have to tell you generally.

Q Right, that's fine.

A The efforts that we have made in foster home recruitment have been through church groups, PTA groups, civic organizations, anywhere you find a group of people that we can go talk to; about every six months or once a year, we run radio spots on the air, put articles in the local newspapers, we have even put a, you know, ad in the local newspaper. Several civic groups have come to us wanting to know something that they could do connected

with our agency for the community and they have run articles pointing out our needs for foster parents or picture one of our foster parents with a little story about them, spotlighting certain foster parents and this kind of thing.

Q Okay, fine. Who would make the decision as to the . . . well, first let me ask you this. We've been talking with the term "foster care" and I realize this is a very general term—do you distinguish between various types of foster care, in other words, are there different types when you speak of foster care—are there different types and would you explain?

A Well, foster care generally means that we have taken the responsibility to place children in an agency approved home, one that we are supervising. The only different types of foster care that, when you speak of different types of foster care, what I would think of is what we say "regular foster care" for [13] those children who come to us from various situations who are in need of foster care. All of our foster homes have been studied and we know the foster homes pretty well—we feel like this child or these children could go into this foster home and make an adjustment and have it be a successful placement. Sometimes there are children with complex problems who need specialized foster care—there are a limited number of specialized foster homes throughout the state—I believe there are only twenty. These foster parents have had training—specialized training in the care of these children and their problems. They are paid more and I believe these specialized foster parents are paid whether or not children are in their homes.

Q What type of training, when you speak of training

of these specialized foster parents—what kind of training would that be—can you give me an example?

A No, I cannot say because we do not have a specialized foster home in our area, but what I have heard is that their training consists of workshops, I mean, you know, two or three days of intensive training to prepare them for the type of problems that they have been handled. Now this, I assume, would be an on-going thing, not just one training period—this would be an on-going thing with specialized foster parents every so often would receive something that would be more of a help to them. The supervision of specialized foster homes from the county department is different also. When we have children who are in [14] what we would consider just regular foster care, it is mandatory that we make one visit a month to that foster home and be available at other times when the foster parents need us or the foster child needs us. But with specialized foster care, the caseworker has to visit once a week and there are probably some other duties and responsibilities that I could not enumerate because I am not that familiar with it.

Q Is there any other type of placement for a child, when we speak of foster care, I mean like a group home—would you consider that another type of foster care?

A Well, yes, institutional foster care.

Q Would that include group homes—the term you just used—institutional foster care?

A Yes, we have a listing of group homes who have signed the Civil Rights Compliance we can work with and make plans for children.

Q You have mentioned now three types of possible placement which were I believe regular foster care, you

said specialized foster care and group home placement, is that correct?

A Yes.

Q Who would make the decision if a child was referred to you as to what type of placement would be necessary for that child?

A No one person would make the decision—it would be a joint decision. We would first have to consider what resource [15] was available for the child. Unless it's an unusual situation, our first choice for any child would probably be a family foster home, but according to what resource is available, the county department staff—caseworker, caseworker supervisor, county director with the help of the Social Service Director would decide what plan would be pursued.

Q The Social Services Director—is that Ms. Autry's equivalent position?

A Yes.

Q What procedures, again if you would, just speak from your own point of view as a local county, like as the caseworker on that level, is there any difference, in other words, what would your role be, assuming that a regular foster home placement was recommended, let's assume that was the recommendation. Would your role be as basically what you've described to me before when we were talking in general terms, terms of recruitment within the county—your role would be to try to attempt to recruit within the county for a regular foster home?

A We have in our county several foster homes which are already approved foster homes. These are our resources—our foster home recruitment is an on-going

thing—we don't wait until we have a child who needs a foster home and then go out to different groups and that kind of thing looking, so the foster home recruitment is an on-going thing. If we have a child who needs a foster home—a family foster home or some [16] other resource, and our preference is a family foster home, then we look to our community, to our foster homes which are already approved.

Q You would be directly involved, though, in that process?

A Yes, I would be.

Q Now you mentioned specialized foster homes—let's assume that a child has come to you and the recommendation is for a specialized foster home—what would your role be in that instance, in other words, if a specialized foster home was recommended—would you be initiating contacts or what procedure would you follow?

A If specialized foster home were recommended, I would go to Ms. Autry.

Q The first step would be to contact Ms. Autry?

A Yes. And discuss it with her and if she were to say, "Yes, I feel also that a specialized foster home is needed", but that's kind of difficult for me to even talk about, because from the very beginning specialized foster homes have been full with a waiting list and they have not really been a resource to us.

Q Assuming that, if you did have a child—let's assume that the recommendation was this child fit into the outline for specialized foster care, what would you do, what would your actions be—I'm trying to get a feel for what you would do in that instance ast he caseworker directly

involved. You men-[17]tioned you'd contact Ms. Autry—would you contact anybody else?

A No.

Q Would you then assume that having contacted Ms. Autry she would initiate any other . . .

A She would probably check with Ms. Black; I feel like she would check with Ms. Black to make sure that this is the situation, or that there would be no other . . . or to make sure that there is not some other alternative open that we could look into.

Q But that action would be on her level, in other words, would you be writing letters to anyone about specialized foster care or would your responsibility be to contact Ms. Autry and make her aware of this situation?

A Yes.

Q You would not then recruit within the county for specialized foster homes—that would not be part of your duties and responsibilities as opposed to regular foster homes?

A No, at one point, we were told that we could recruit a specialized foster home here in our area, but we didn't have any success as far as recruiting a specialized foster home, but I would not be . . . as I said, again, we would not wait until a child came to our attention to start recruiting for a resource, you know, we build what resources we can while we can.

Q Sure, I understand that. Specifically now, I would [18] like you to refer to Joey's case—you mentioned that your first contact with the case was in November of 1973, is that correct? Not . . . I mean . . . okay . . . the first time you heard about it, not a formal contact—we don't have

to go into that; I appreciate what you said before, but Joey's case was first . . .

MR. LACKEY: Counsel, maybe I can explain . . . she has been familiar with this case long before he came to Central State, a small community—they are aware of the situation and were aware of it before—that is what her quandary is—she doesn't know how far back you want her to go.

Q Okay—in your capacity as a caseworker for the Baldwin County Department of Family & Children Services, when is the first time that Joey's case came to your attention—in that capacity?

MR. LACKEY: Answer as best you can as you understand the question.

A I became involved with Joey and with his current situation in November of 1973.

Q Other than in your capacity as a caseworker for the Department of Family & Children Services, when did you first become aware of Joey?

A Well, when . . . before Joey came to Central State Hospital our agency was aware of some complaints in the community that were made concerning Joey and I was not the caseworker that handled this, but I worked with the woman who did. I had picked [19] up some complaints within the community because I live . . . I knew several people who lived in the trailer park where Joey and his mother were living, and some of these complaints, you know, came to me and I got . . . these people came to talk to Ms. Lloyd, who was then our Child Welfare Worker, and Ms. Lloyd had an interview with Joey's mother and felt that Mrs. Sherma was aware—she was Mrs. Lister

then—was aware of Joey's problems and was doing the best she could with Joey.

Q Let me be more specific, I think it will be easier. When was your first personal contact, you personally having contact with Joey himself at any time?

A I guess that would be about December, 1973.

Q Okay, fine. What was the background of how that meeting came about—that you happened to see him in December of 1973?

A I had been contacted in November of 1973 by Carolyn Grant, the social worker at the Children's Building, by Betty Harris, the registered nurse who was Joey's primary therapist at that point and I went to Central State for an appointment with Ms. Harris, and I saw Joey.

Q May I stop you and let's get something clarified?

A Yes.

Q Let's get something clarified right here—what is your understanding of the role that Baldwin County Department of Family & Children Services plays with patients, specifically [20] children who are at Central State Hospital—could you explain that first?

A I'll try. We are called on quite frequently from Central State and from other county departments that are supposed to handle many things that involve patients at Central State Hospital. Unless a child, speaking specifically about children, unless they fell into one of our categories for a program—for one of our service programs—we would really have no responsibility for them.

Q Are you aware of any regulations, guidelines, agreements as to . . . that would set out like what Baldwin County Department of Family & Children Services'

relationship is with, again confine it to children, with patients at Central State Hospital?

A Well, we have many federal and state guidelines, and a lot of these guidelines have to do with family income, with income . . . I didn't mean to say income again —have to do with family incomes, with their classification there, and also with children who are with other resources. Joey, or any other child being at Central State Hospital, had a social worker, a therapist, medical attention, you know, he had all of these things as resources at Central State, and until we became involved with this, unless there were a need outside the hospital, we had no responsbility.

Q Could you elaborate on this need outside the hospital? Could you be a little bit more specific on what that might be?

[21]

A Joey was placed in the hospital by his family—by his legal family. Our agency was in no way involved with that. Joey was in the hospital several years and he did not come to our agency's attention. The assumption would have been that this child was getting what he needed from the hospital or at the hospital. When they felt . . . when the hospital staff felt there was a need for our agency to become involved, they contacted us. Let me add this, too—children who are in . . . people in general, people who are in state institutions who are in other places where there are federal and state funds going are often not eligible for our resources because that is such a duplication of services, but when there is a specific need or a part that we can play, they do call on us; sometimes we will fit in.

Q Would your first step in such an instance be to investigate the situation and see if the Department of Family & Children Services would or could become involved; if it was necessary for them—is that what you're saying?

A Yes, that's right.

Q And if there was this need for help outside of the hospital, that's when you would continue, if that was found, that's when you would continue any services on the part of the Department of Family & Children Services?

A I'm not sure I follow what you are asking now.

Q Well, okay, I'll tell you what I'll do; let me summa-[22]rize what I think you said, and then you just correct me or just tell me if I'm . . . if not, please elaborate. If, as Baldwin County Department of Family & Children Services, okay, if a patient at Central State Hospital comes to their attention, what you would do as a first step would be to investigate or just look into the situation surrounding the patient and see whether they were eligible for your services? In other words, it is not an automatic, in other words, that a child, let's go with children in Central State Hospital, patients, a referral to you would not automatically mean that you would—Baldwin County Department of Family & Children Services would continue to follow that case, would automatically accept that case of that child, is that correct?

A That's correct.

Q Okay, fine—I wanted to establish that. You mentioned that your first contact in November, 1973 was from Central State Hospital personnel?

A Yes.

Q Okay—what was your understanding then of the contact—what information was conveyed to you by the Central State Hospital personnel at that time?

A The social worker in the Children's Building called me and what we talked about that day—the main thing that I remember talking about on that day was the fact that Mrs. Sherma . . . Mrs. Li—Mrs. Sherma wanted to release custody of Joey. I [23] think it was also mentioned about maybe a future plan or resource for Joey outside the hospital in the future, but at that point they were telling us that Joey was not ready.

Q Okay, would you like to continue?

A Continue with—where would you like me to go from there?

Q You had mentioned . . . We had talked about a December 1973 meeting—could you tell us like . . . and you mentioned the first contact was in November . . . what happened then, what steps were taken after you received the referral from Ms. Grant?

A Ms. Grant asked that I talk with Mrs. Sherma and I told her that I would, but I requested that Mrs. Sherma make contact, because this is involving the parents, letting them be in on the planning as much as possible and when people come to you with requests such as this, we feel like it's better to let them make the initial contact . . . to initiate contact in some way. So Mrs. Sherma did call and make an appointment; she came into the agency and I talked with her on that occasion about different ways that we accept custody of children and . . .

Q Excuse me—could you elaborate on that—what are the different ways?

A I explained to Mrs. Sherma that sometimes we do accept voluntary releases on children . . .

Q Voluntary meaning from the parent, if there is one?

A Yes, from the legal parent or parents. I explained to [24] her that we get releases through court orders, that every situation is different and that I was not entirely responsible for saying how this would be handled, and that I would discuss this with my Social Service Director and would be in touch with her to let her know where we could go from that point.

Q What was the substance—you say you spoke with Mrs. Sherma about her desire for what was going to happen to Joey—what did she express to you? In regard to his future?

A Okay—Mrs. Sherma said that she would like for Joey to be someplace other than Central State Hospital, that she and her husband had reached a decision that he could not come back into their home, that they could not function with Joey, and he could not function with them.

Q Okay. And she was coming to you in order to find out what her alternatives were given the fact that she and her husband were not going to . . . had made the decision they would not take Joey back into the home, to look to you for alternatives, is that correct?

A To us and to Central State Hospital for alternatives. One of the problems that we had with this case would have made it easier for us to work with would have been if we had been involved in this case earlier, if it had been referred to us about the time that Central State Hospital . . . the staff of the Children's Building had begun working with Mrs. Sherma.

Q How would that be, in other words, do you have a [25] regular communication going back and forth between Central State Hospital and Baldwin County Department of Family & Children Services—would it be on the initiative of personnel within Central State Hospital to bring you, make you aware of a situation, is that how it would come about?

A Yes. There was a plan made here with Mrs. Sherma to release Joey to our agency and at any time, a voluntary release of a child is given, the other party has to be accepting and Central State Hospital—the personnel there did not know, really enough about our policies and procedures and the way we plan for children—what I'm saying is that we were not involved earlier—early enough in this situation to be able to say . . . let me go back . . . Central State Hospital personnel worked with Mrs. Sherma and helped her reach the decision to relinquish custody of Joey, and at this point our agency was the only agency—there was no other alternative with anybody to release Joey. Then they contacted our agency, so we had to start from the beginning and say "This is the way it is with us".

Q Okay, fine. What was the result of your talking with Mrs. Sherma . . . did you indeed then talk to Ms. Autry about the situation, and if you did so, what was her recommendation?

A Ms. Autry was not in her position then—it was Ms. Val Weathers. And I talked with Ms. Weathers—this was such an unusual situation that she talked with Juanita Black, who was the Regional Program Director. I am not sure with whom Ms. [26] Black talked with in the state office, but I do feel like she talked with other personnel in the state office, but word came back down to me through Ms. Weathers that we could not accept a

voluntary release on this child, that we would request that the parents go to . . . go into the Juvenile Court and petition the court to place Joey in our custody, and we would . . . we were asking that we not be given permanent custody, but that we would want to accept temporary custody of Joey, because with a child Joey's age and with his problems, we really could not do anything more with permanent custody that we could not do with temporary . . . that we could do with temporary custody, do you understand what I said there?

Q Yes. Were any reasons given as to coming . . . to the best of your understanding, as to why that particular recommendation was made, that the parents in this case petition the court?

A Yes, because we did not feel that Joey fell into the category of a child that we could either accept a voluntary release on or that we could go to court ourselves and ask for custody. He had two legal parents—we did not feel at that point that he was abandoned, abused or neglected, and . . .

Q How would you define "abandon"—what does "abandon" mean to you?

A Well, "abandon" means to me that a parent has completely left a child alone for a very long period of time, that [27] parents cannot be reached, their whereabouts are unknown.

Q Does the Department in other instances, like if a child was being abandoned, does the Department, is it your understanding that as a regular course, that they do have the power to go into Juvenile Court and to request temporary custody on their own of that child?

A Yes, if we felt a child was abandoned, we could do

that; I do know that different courts have different feelings about abandonment and I know from experience that other caseworkers have related to me in instances where parents have . . . parents of infants . . . cannot be located, cannot be found, the courts are very slow to give us custody.

Q But in your experience and your understanding of what a local county Department of Family & Children Services department can or cannot do, they can if they deem the situation that a child is in let's say an emergency situation, that he has been abandoned, if they feel he's abused, like an emergency situation, that they feel in the best interest of the child, he needs to be out of that situation, that they can initiate and be the petitioner, let's say, to Juvenile Court to attempt to get temporary custody, is that correct?

A Yes.

Q You mentioned a personal contact with Joey in December, 1973—at what other times have you had personal contact with Joey, and from that I'm speaking from December, 1973 up to the present—how many times have you seen Joey personally?

[28]

A Probably, oh eight or ten times.

Q Do you, as you mentioned before, we established that you do keep a file on Joey—a file is kept on him . . . how do you get information for your file about Joey; I assume, I just asked—you mentioned you've seen him eight or ten times, in the times that you . . .

A I obtained information from his record at Central State Hospital . . . medical records, psychological nurse's notes, and this kind of thing.

Q Do you do that on a systematic, regular basis; in other words, do you request, let's say, a monthly report from Central State Hospital as to how Joey's progress, or do you receive things automatically or do you just . . . when you specifically request it?

A When I request it, when anything really significant happens, the personnel there will contact me.

Q When you say significant, could you explain what you mean by that?

A Well, if anything significant happens and . . . if anything happened with Joey's home situation, contact with a parent or someone else becoming involved with Joey . . . we worked a little bit, not thinking so much about a foster home for Joey; the personnel at Central State, speaking of Ms. Harris and Ms. Grant and I suppose his psychologist and others involved with him there felt that if we could have someone involved with Joey, just someone to take him out of the hospital once in a while, someone [29] to show some interest in him, not especially working toward a foster home placement, that this would mean a great deal to him.

Q You've mentioned now . . . we've talked about three different areas that you or Baldwin County Department of Family & Children Services, like address themselves to in the case of Joey; we talked about working with Mrs. Sherma in terms of this relinquishment of her parental rights, you've mentioned now like a sort of service . . . a social service in terms of providing him with some contact . . . was there a third area that you worked in in terms of a long range goal at his foster home placement?

A With Joey?

Q With Joey?

A I can't say that I have worked too much in that specific area because I knew right from the beginning that we had no foster homes here in Baldwin County that could cope with Joey. We might have had one possibility of a home that might have had Joey, but this home was full and was filled with younger children and we felt that we could not take the responsibility of placing Joey in a home where there were younger children.

Q Was this home that you mentioned about that you had considered, was that . . . at the time you were considering, was that in 1973 or has it been just recently or when was that?

A Well, it was not recently, but it would not have been in 1973; it would probably been more somewhere like summer of [30] 1974, spring, summer, 1974, somewhere along in there.

Q Was that the main, that you could say like in the last two years, was the primary effort then would you say, as the caseworker for Baldwin County on this case towards the . . . working with the Shermas, towards their voluntary relinquishment or the procedures whereby they would give up their parental rights and the services aspect that we mentioned before, would you consider those your primary responsibility in this case?

A Yes, I would not give one priority over the other because Joey had been on my mind like a lot of other people's minds, I'm sure; as to his wanting very badly to be somewhere else than Central State Hospital. Now our understanding of Joey's condition has been that he fluctuates in what they feel . . . what the staff of Central State feels is a readiness for another placement, and . . .

Q How did you receive this information; in other

words, when was the first time the Central State personnel spoke to you in terms of a long range goal for Joey and their recommendation in that regard?

A November or December of 1973, during some of those contacts, as to what we would work towards in the future.

Q It was your understanding that their recommendation at that time . . . that that's what Joey needed?

A I don't know if I could say it was their recommendation because I would talk with them one week and they would say that [31] Joey's behavior was fine, maybe we could work towards this . . .

Q Then other conversations that you had with Central State Hospital personnel, you mentioned records, that you looked to records at Central State—did the records indicate to you that the personnel that were involved there with Joey—needed foster care?

A The records would have been the same; the records, you know, we would get a copy of a psychological or some ward notes or something that would point out Joey's severe behavior problems, then we would get something saying that he had improved, then it would be something that he was regressing a little. What we felt like we had to to on was to whether or not a resource that we had available for Joey could cope with, how severe his behavior was or how serious his behavior problems were.

Q In the conversations or within the reports that you looked through at Central State Hospital, were there any specific recommendations in there—we talked previously in general terms about types of foster care, regular, specialized, group homes or as you mentioned, institutionalized, did it come to your attention through any of the personnel or records at Central State Hospital as to

what their recommendation was for the type of foster care for Joey and if so, when?

A I don't believe that Central State Hospital personnel was familiar enough with our foster home, foster care programs [32] to be able to say what kind of care they felt that Joey needed.

Q Let me just clarify that . . . it'll make it a little bit easier for you—I didn't mean specifically notations in their records as to what Baldwin County had in terms of foster care, but their recommendations in general as to the type of foster care that Joey needed, either with . . .

A I'm not sure that I could pinpoint anything written in my records from Central State Hospital, but I do know that in talking with Betty Harris and with Carolyn Grant, who had been the main people that I've talked with at the Children's Building concerning Joey, we have all been in agreement that Joey needs a very special foster home setting.

Q Do you mean specialized foster care, in using that, is that synonomous with very special foster home, or do you mean like a regular foster home with very understanding foster parents?

A Well, I'm saying specialized foster care, but at the same time, there may possibly be a family, just a regular approved foster home, who might be able to cope with Joey, but this would still have to be a very special, not specialized, but a very special family who have the patience, the ability to cope with a child such as Joey, who have the time and attention to devote to Joey—we have all felt that Joey needs to be in a foster home where he is the only child, where the mother has a lot of attention to give to Joey, and this kind of thing.

[33]

Q Yes, I understand what you're saying; given that, you don't recall the first time that you specifically talked with any of the personnel, either Ms. Grant or Ms. Harris, or anyone about this type of home that you know, you all agreed was necessary for Joey—do you remember the date, I mean, do you remember approximately . . . was that also maybe in 1973 or 1974?

A Well, that was probably nearer the beginning of 1974 because my contacts in 1973 were late in the year, and it probably was the beginning of 1974 when I got the material on Joey. I wanted to say . . . do I have to wait for you to ask questions or can I say . . .

Q I think we may get to it through my next series of questions, if not, you can add it on. You got the materials the beginning of 1974 and sometime in early 1974 you had these discussions with the Central State Hospital; you spoke of agreement as to this type of home described for Joey's needs—what, in your capacity as a caseworker, what actions did you then take?

A I continued to keep Ms. Weathers, who was the Social Service Director at that point, to keep her up to date on what was going on between me and the Children's Building. A copy of the material that I received on Joey was sent to her.

Q What other contacts from January, I'll specify early 1974 continuing to this date, have you made?

A In January of 1974—can you wait just a minute and let me get my notes out?

[34]

Q Sure, that's fine.

A I can't remember whether it was in . . . it was in December that I talked with Mrs. Sherma and we discussed the relinquishment or whatever of the custody of Joey at that point; and Ms. Weathers, after she talked with the people that she was responsible to said that we could not take a written release from Joey. I had an interview with Ms. Harris and Ms. Grant in the Children's Building, and this would have been either very late December or January of 1974, and explained to them that this is what had been said, that this would be our request, that they petition the court to give us . . . the parents of the child petition the court to give us custody of the child and that we would like to start off . . . we would like to have only temporary custody. We made an appointment with Mrs. Sherma and I went back to Central State Hospital and had an interview with Mrs. Sherma and Ms. Harris and explained to them again our agency's position concerning taking custody of Joey; and Mrs. Sherma at that point said that she understood and that she would talk with her lawyer about how to handle it with her ex-husband, who is the legal father of Joey; and she lead me to think that they would go ahead and initiate action.

Q Finish what you were going to say.

A I heard nothing until early May, 1974 when we received a copy of kind of a release, a voluntary relinquishment signed by Mrs. Sherma and Dr. Lister, notarized—it was not signed by [35] a judge, it was no order or . . . it was just notarized, and I sent a copy of this release to Val Weathers, who took the release to Ms. Black . . .

Q Let me just stop you and I'll let you continue in a second. What efforts did you make between January 1974 and April 1974 when you received this copy of the voluntary relinquishment to secure some type of foster home placement for Joey?

A What effort did I make?

Q That's correct.

A At this point, I was not sure that we would be pursuing a foster home placement for Joey because we were not sure that Joey was ready for a foster home. Going back to what I said . . . what I was talking about a minute ago in getting somebody else just to have an interest in Joey, to find him a resource outside the hospital, I made just some community efforts . . . to give you specific instances, say . . . would you want these?

Q Did you make any written inquiries or was this basically your just generally feeling out what was available?

A This would be within the community, so there were no written efforts. Ms. Harris, who was in the Children's Building that I've been speaking of, was doing the same thing.

Q Could you continue . . . you had been explaining up until April 1974 . . . what happened after April 1974 specifically in regards to your efforts for foster home placement for Joey?

A I have been aware all along of what our resources are [36] here in Baldwin County and there was nothing that we could really fit Joey into here, and anything that has come to my attention that might possibly be something that we could develop into a resource for Joey I have been aware of in making any efforts in the community.

Q How about in regards from January . . . again, early 1974 whenever you had the conversation with Ms. Harris

and Ms. Grant and came to the agreement that what was needed for Joey was a specialized foster home or a very special regular foster home—what efforts did you make after that time continuously in terms of specialized foster care home, let's say that specifically . . . I understand what you explained about a regular foster home and your efforts in that regard; specifically as to specialized foster home, what actions were taken by you?

A Well, Ms. Weathers was aware of the feeling of a need for a specialized foster home for Joey, Ms. Black, who was the Regional Program Director was aware of the need. When Ms. Weathers left her position and Ms. Autry came into that position, she was immediately aware of the need too—I believe this was the first case that she had anything to do with . . . directly to do with in her capacity as Social Service Director. She was aware immediately of the need. We did not have a specialized foster home in this area, we didn't seem to have a resource for one, and very shortly after that, the funds were withdrawn for us to develop a foster home in this area, and that was all we could do.

[37]

Q Did you make any written requests, other than again, like did you make any written request to anyone on the state level or on any of the levels that you've spoken about before you yourself as to specialized foster home for Joey?

A No, I would not do this—Ms. Autry would do this.

Q Okay, but you made your contact?

A Yes.

Q That's what you have done in your capacity?

A Yes.

Q Since the time we are speaking, that's since April 1974 to the present, have you continued to make attempts or efforts to explore placement-foster home placement for Joey—regular this time?

A Since when now?

Q Okay, let's go back . . . let's just start this over. From early 1974, the first time you talked with Central State Hospital personnel, agreeing as to the type of home that was needed for Joey, have your efforts been continuous since that time to seek a foster home for Joey and if so, can you specify and be as specific as possible as to what those efforts were?

A I don't know another word to use except responsibility—my responsibility, my area of working with this case as far as finding a resource for Joey, would be, finding a foster home for him would be confined to Baldwin County. I guess I can . . . or I feel like I can say that this effort has been con-[38]tinuous in that I have known continuously of our resources here in Baldwin County . . . I have known continuously of any possibility of new resources . . . we have continuously from time to time made an effort to say to somebody "Would you be interested in this child or is there any possibility that you could have an interest in this child or do you know anybody else who has . . . it has been this kind of thing here in Baldwin County.

Q You were explaining why I wanted to clarify those particular points, the Department's role in terms of their accepting or adopting custody of Joey and you were explaining that you received this paper that voluntarily relinquishment of rights from Mrs. Sherma in April 1974, is that correct?

A The paper was signed, I believe, in April of 1974, and we received it in May.

Q What happened after the Department received that?

A I sent a copy of that paper to Val Weathers, who I'm sure showed this paper to Juanita Black and I believe that it went to Ann Hunter, who is Head of Social Services in the state office, and the general consensus was that that paper was not legal, that it could not be considered a legal release. We met with Colonel Schuyler here at Central State and talked about the release and explained that Central State Hospital could not take custody of the child and that the release just really could not be considered binding or legal—Central State Hospital or our agency was not a consenting party to the release.

[39]

Q Assuming that, if you had been successful, let's say in March of 1974 and had found a foster home that would have met the needs as you defined them, that Joey require or would need in a family or foster home setting, would Joey have been placed there?

A Joey could have been placed in the foster home without our agency having custody; there are some resources that we would only be able to use, you know, with our agency having custody, but if we had a foster home, a specialized foster home, we can take voluntary requests from a parent for a foster home placement for that child.

Q That could have been done, if indeed you had come across a foster home that again, was suitable for Joey's needs—he could have been placed?

A Yes. (Directed to Mr. Lackey—can I borrow your pen?) (Directed to Ms. Lindbloom—I just wanted to make a note of something—is it okay?)

MS. LINDBLOOM: Sure. Could we just take a short break?

(BREAK IN QUESTIONING)

Q Ms. Etheridge, has it been your understanding from Central State Hospital personnel or records that the recommendation which you've spoken of in early 1974—their recommendation as to the type of foster home that Joey needed at that time, remains their opinion or remains to be what's recorded in their records at the present time?

[40]

A Are you speaking of the need for a specialized foster home or . . .

Q Specialized or very special as you say regular foster home?

A Yes.

Q In that regard, you've also mentioned the service function that you've performed in setting up . . . has your agency set up visits for Joey with other families, let's say at holidays or vacation periods and the like?

A No, because we have had no success in finding anyone who was interested in, you know, having Joey, even for brief periods of time and we have no resource for finding something for this kind of need except to go out into the community and ask and look.

Q Did you make any contacts-to the best of your knowledge did the Shermas have any further contact with Joey after late December 1973?

A I don't think so; now they could have had some in early 1974, but I don't believe any more after that.

Q Did Central State Hospital personnel inquire to you and rquest that your agency possibly set up some visits with families for Joey for vacation periods and various holidays in the last two years; that is, from December 1973 to December 1975?

A Yes, I could say two things on that matter—they did not contact us and say . . . well, what they contacted us and said [4] was "Do you have something available for this?"—and when we had to tell them that we did not, you know, they didn't like it, we didn't like it, but they were accepting of it, and that's the way things were.

Q Okay, so Baldwin County Department of Family & Children Services has not been setting up visits for Joey on vacation periods—that's not something that you've been doing?

A No, we have not. We have gotten letters from Central State Hospital, form letters that are sent out to parents of . . . parents or guardians or whoever of each child saying that the vacation paper . . . vacation period for Easter, Summer, Christmas, is such and such a time, let us know what your plans are, and we've been back in touch with them and said, you know, we'll look and hope something comes up at the last minute, but, you know, we just don't know of anything that we could plan for.

Q When you look for your general, as you mentioned, your on-going efforts you have to look for recruitment of foster homes within the county, are there certain children that you consider priority children that you consider more important than others in terms of finding a foster home?

A The one priority that we would make there would be going back to what I said previously that children who are in a home or in a living situation where they are in immediate danger would be given first priority for a foster home.

Q How many children are you presently looking for . . . I [42] realize the recruitment effort is on-going, but how many children right now that you have, let's say on your caseload, are you seeking foster home placement for besides Joey?

A On my caseload I have probably eight to may fifteen children who would be better off in a foster home.

Q What do you mean by better off?

A Well, they are not . . . these children are in their own homes; there are two children who are in a foster home, who are in a foster home at this point now, that their foster placement is not working . . .

Q If you had to take those eight to fifteen children you are talking about now, would you place a priority on . . . I'm sure it's easier for you to talk about priorities with actual children that you have on your caseload—are there children among those eight to fifteen, including Joey, that you consider a priority?

A Yes, all except two or possibly three of the children; these three children are already in a foster home, they are being given adequate care—the foster home placement is not working, but they do have a place to stay where they are cared for and protected. The other children, besides Joey . . .

Q Well, if you can relate those specific ones that you would consider on the top of the list, you don't have to

describe all of them, but if you can describe the situation of those you consider priority of the eight to fifteen cases, and include [43] Joey in those?

A No, I can't because the other children besides Joey are children who are in their own homes, who are not receiving the care that they should be receiving. Most of them are with their natural parents, maybe with one parent, the mother; she is not caring for these children as a foster parent would. She . . . they don't have the stimulation and in a lot of cases they don't have the love, and this kind of thing that they would in a foster home.

Q I'm appreciative and I think I understand what you're saying that all of these children probably need something . . .

A Can I go just a little bit further?

Q Okay, why don't you continue?

A Okay . . . let me go just a little bit further; all right, so all of these children are in about the same situation, but with this type of situation, we work with the family and try to hold it together because if there is any way we can keep that natural family together, that is the best thing, even though right now the children would be better off in a foster home, but maybe today or maybe tomorrow, there will be a tragedy of some sort and the situations in one of these families will be a real bad abuse case, you know, maybe the mother's had all she can stand emotionally, financially or whatever and has beaten the child very badly or she says "I can't cope"—then this child would get a priority for a foster home.

[44]

Q Okay, let's just take a freeze . . . a moment in time, which is right now—we have no emergencies, we have

just those people on your caseload and I'm appreciative of the fact that you are making this on-going effort to recruit foster homes within Baldwin County, that you have not had great success in turning up numbers of foster homes. Let's suppose now that you have one couple . . . you have a foster home opening and you have those children that you just described—clearly, you have to make a choice, wouldn't you, if you do have one foster opening and you have those children—that's basically what I meant by priority; can you basically tell me which of your children would get priority?

MR. LACKEY: Council, how can she answer that question if you can't be more specific about what kind of a home, what kind of couple you are talking about, what kind of resources they have? When she mentioned priority twice now, she talked about an immediate life or death type situation as being her concepts of what a priority was—I don't see how she can answer your question.

Q Yes, but I'm speaking . . . let me say if I can explain this better to you. You've had problems in securing large numbers of foster homes within the county, is that correct—is that a correct statement?

A Yes, it is.

Q Given the caseload that you have and I appreciate the [45] fact of emergency situations and that special situations arise and that is a priority in one sense. I'm trying to get a feeling from you of the caseload that you have now, that if a foster home . . . let's make an assumption, that this is a foster home, a very special regular foster home . . . you've checked it out, it's been an approved foster home and you have to make a decision as to which of the current caseload, and you've given us a detailed account of that—which of those children would

you, given the fact there are special circumstances in each of those cases?

A I think . . . is what you've asking me, if I had a vacancy in one of my foster homes here in Baldwin County, which of my children would I fit into it?

Q Right, exactly?

A Well, going back to what Mr. Lackey said, it would depend on which foster home, to me I supervise . . . I'd have to name and count off right now six or seven foster homes here in Baldwin County. I think three of those foster homes are approved for specific children. The other four foster homes the children come and go as the need is. To me, all these foster homes are . . . I'd have to say that all of these foster homes are in themselves, that the foster parents are special people because even with children who do not have problems such as those that Joey has, they are a lot of time, patience, a lot just having to give to strange children who come into your home who are not able to be . . . who have to be in foster homes.

[46]

Q Let me just zero in on this and I can save us some time. Do you regard Joey's situation and by that I mean, having received reports from Central State Hospital personnel since early 1974 that he needs to be placed in a specialized foster care home, assuming that's the situation, he's presently confined in an institution, do you consider that situation . . . how do you rate that—do you regard the necessity, his necessity for placement in a foster home, let's say as greater than the children you've remarked who are in their natural homes now and you're attempting to work with the family, the urgency of Joey's situation?

A The one advantage that we would see Joey having would be that he is in a place where he receives care, protection, this kind of thing. I don't see our agency ever being in a position where we have a foster home and would have to choose between placing Joey in that foster home or another child in that foster home. If we ever were in that position, I can't say which child would have priority.

Q If the number of slots in existing foster homes, though, is limited, would you not of necessity have to make a choice which children would remain on your caseload as your . . . continuing to look for foster homes for them, and I mean that slot would have to be filled, is that correct?

A No, it would not have to be filled. As far as my caseload is concerned as of about approximately five or six [47] o'clock yesterday evening, all my protective service cases are okay right now, you know—there are no particular crises, and if we had a vacancy in a foster home, I would not just choose to take one of these children out of this family when things are all right now and place him in a foster home. That vacancy might remain in the foster home or we might have a call for that vacancy from another county . . .

Q Is what you're saying that if a vacancy should arise that it is possible in your experience with working with the Department that vacancy may stay open for various reasons for a while, that it wouldn't automatically . . . a child would not automatically be placed?

A No, if we had a child waiting in our district or if Nancy or Ms. Black was aware of a child in another district or region who needed that home and would fit into that home, then that child would be placed in that

home, but we would not go out looking for a child to take ouf of his natural home.

Q No, I did not mean that; I meant children who are on your caseload already that you are currently aware of . . .

A Who are on my caseload?

Q Yes.

A No, not if things are going all right in the natural family, you know, if . . .

Q Have there been any vacancies in foster homes within the county of which you are aware of since January 1974?

[48]

A Yes, there have been.

Q Was Joey considered for any of those placements?

A I would . . . I don't know whether to say yes or no to that . . . let me put it this way—these are foster homes, we have one foster home who keeps only infants, they are approved to keep only infants; Joey would not have been . . . would not have been considered for that home.

Q Right.

A The other foster home—the mother had an operation on her leg, was on crutches for a period of . . . in the hospital on crutches for a period of time, and she could not have taken care of Joey or any other child during that time. We have . . . I can't . . .

Q Those are the only vacancies that you can . . . that you are aware of, that you can think of at the present time?

A Yes.

Q Since January 1974?

A Yes.

Q Would that mean that given the fact that Joey was not appropriate obviously for an infant foster care home, that he was not considered for any local county foster homes, then, since January 1974—actually consulted when there was an actual vacancy available?

A No, because we knew . . . because we knew that Joey could not go into these foster homes.

[49]

MS. LINDBLOOM: Excuse me just a second.

(OFF THE RECORD)

MS. LINDBLOOM:

Q Have your efforts changed any since early October . . . excuse me . . . late October or early November of this year in regard to Joey, in regard to the court order granting temporary custody from the Juvenile Court judge, giving temporary custody of Joey to the agency?

A At the time of this hearing, Joey's legal father came forth and did express some interest in the child. The judge placed temporary custody of Joey with our agency, but stipulated that we would look into the possibility of placing Joey with his legal father and his family. We have requested that Thomas County—that's the county where the legal father resides—we have requested that they do a thorough home evaluation, we have sent them copies of all of our material on Joey that would be pertinent to them, what background information we have on the legal father, information on his natural mother here, anything we could send to them to help them make . . . to under-

stand Joey's need and to make this evaluation. That has been done since the court hearing which was held on November 24. In October, Nancy Autry referred Joey to Child Service and Family Counseling in Atlanta and I think it was Friday before the hearing on the . . . that was on the twenty-fourth, two people from Child Service and Family Counseling came down and interviewed me and Ms. Autry [50] and the staff at Children's Building and Joey.

Q Could you explain this Child Service and Family Counseling—are they a referral agency?

A Yes, they are a private agency in Atlanta—they have a specialized foster care program and they do accept referrals from other agencies, but we understand that waiting list is long and the waiting period is long, but a referral has been made, they are interested in Joey and have been down to talk with us and to see him.

Q Other than the Child Service & Family Counseling Center's efforts as a private agency, since the time that you made the contact with Ms. Autry regarding a specialized foster care home for Joey back in early 1974, what is your understanding, or have you received any comunication or documentation that efforts have been made within the State now in terms of finding specialized foster care for him to the present time?

A All I can say to that is Ms. Black is familiar with all the specialized foster homes throughout the state, she knows that they are full and that we have a waiting list of children to go into those specialized foster homes and it has been maybe approximately two weeks ago . . . no, it was the day of the hearing, the custody hearing . . . it was a week ago Monday on the twenty-fourth that Ms. Black again stated that she had recently checked to make sure

and that they were all the slots in those specialized foster homes were full.

[51]

Q Ms. Etheridge, to your personal knowledge, have you received any written word or did Ms. Black or did any of your superiors communicate to you that Joey had been placed on any kind of list for specialized foster care or was given any type of priority for that?

A I don't know because I don't know what kind of list is circulated; I don't know . . .

Q Okay, fine . . . excuse me, why don't you continue, I didn't mean to cut you off.

A That's okay, but I just am not familiar enough with how . . . with what . . . as I said what kind of list is circulated or how that waiting list is handled. We have several regional program directors and each one of those knows which children in their counties are in need of those specialized foster homes, from there I don't know how it's handled.

Q That's fine—I just wanted to know whether it was in your personal knowledge. I have one last question for you, okay? In your efforts in locally recruiting for a foster home, if you were to be explaining Joey, if you were to give a brief description, let's say, to a possible foster home, or to people that might be potential resources for foster home placement, if you were to describe him in just a few words, what characteristics, you know . . . what would you say based on your knowledge?

A I would say that this is a twelve year old boy, would give some background about him being at Central State since such [52] and such a time, that he exhibited

while in Central State serious behavior problems, many of those behavior problems continue to manifest several of these problems.

Q What problems are those?

A Impulsive behavior, short temperedness, a low frustration threshold, wanting to have his own way most of the time. I would say that this is a child who needs extra time and attention, that he has special needs in you know, needing this extra time and attention, he would need to continue in school here at Central State or some sort of special education school and I feel like this would be more than just a regular special education classroom in the public school system, this kind of thing.

Q Ms. Etheridge, do you agree with the Central State Hospital personnel that Joey needs immediate placement in specialized foster care or a foster care home?

MR. LACKEY: There is no evidence that Central State personnel say he has to have immediate placement in a foster care home.

MR. GOREN: It's in the stipulations.

MS. LINDBLOOM: (Directed to Mr. Lackey) Do you want to see it?

MR. LACKEY: Yes, let me see it. (Examines stipulations)

MS. LINDBLOOM: Maybe it will be easier . . . why don't I quote from this to Ms. Etheridge, okay?

MR. LACKEY: What are you quoting from?

MS. LINDBLOOM: I'm quoting from the exhibits that were attached to stipulations of facts, okay? Ms. Etheridge, I refer now to [53] a June 1975 Central State Hospital summary progress note on Joey Lister, signed by Betty Harris and Odelia Gutierrez, in which they state and I quote "He is obviously suffering from some degree of institutionalization and should experience success in a loving, concerned relationship as soon as possible." Also in quoting from the psychological evaluation from Central State Hospital dated July 9, 1975, signed by Ryan Lincoln, the psychologist for the Children and Adolescents' Unit, in which he states "Continued hospitalization would not provide the emotional climate necessary to meet Joey's needs and it is my recommendation that Joey be considered for foster home placement with continued out-patient therapy.

Q Are you aware of those two reports, the Central State Hospital reports that I've just referred?

A I'm not familiar with that report from Mr. Lincoln; I don't think that I'm familiar with the report from Ms. Harris either, but my only contact with Mr. Lincoln has been very recently and nothing direct, but in talking with Ms. Harris, this is what she had said, this is what, what I feel, that Central State does not offer what Joey needs in the way of an emotional climate, that a foster home or another placement would offer him more in this area, but whether there is or ever would be anybody that could cope with Joey, with his behavior problems, or whether he would be able to adjust or be able to have another living arrangement, you know, would be in question.

[54]

Q In your mind, that's in your opinion?

A That's the way I feel.

Q Have you been aware of any visits that Joey has

made since December 1973 either on the vacation periods that you spoke about, which Central State Hospital sent you the form letters requesting, you know, noting that Christmas vacation was coming, Easter vacation was coming and did you know anybody . . . are you aware of in your record have you . . . do you have any reference to any visits that Joey made to other homes other than to the Shermas?

A Joey visited with a family in Eatonton a couple of times. I think there was another family that came to see him here at the hospital and nothing developed; now Ms. Harris arranged these but I was aware of them. She met these people through a church in Eatonton, a pastor who used to be here who now has a church in Eatonton. I'm aware that Mr. Goren had him a week during summer vacation and it seems like another weekend . . . then Thanksgiving weekend. One family contacted Ms. Harris about . . . back during the summer . . . about being interested in Joey and we arranged about three different appointments with this couple and these appointments fell through; they went on a long vacation, they both went back to school and now they say at this time they cannot be interested in Joey, and this is the way things have gone.

Q Is it your understanding of these visits that they [55] were successful; in other words, were there any major problems to the best of your knowledge from what you know about these visits, were there any major problems or were they just normal visits?

A I don't know about the visits in Eatonton, you know, what went on there. I don't remember how much of a progress report or how much was said to me about those visits.

Q Do you have anything written in the file, let's say, you've mentioned conversations with Ms. Harris, do you have anything in the file as to visits that Joey has made to other homes and as to their success or lack of success—have you kept any kind of record as to those visits?

A Nothing except maybe some narrative saying that Ms. Harris . . . Ms. Harris knows pastor; she has asked about any members of his congregation be interested in Joey and then maybe making a note that there is a family in Eatonton who is interested and will take Joey, that kind of thing.

Q In your narrative there?

A Joey is a child . . . we know what his behavior is and a lot of times just behavior that may be acting out that one family, maybe a family would feel like they couldn't cope with that was for them to take, maybe for Joey that might be pretty good.

Q Do you have any indication in your own records or your own knowledge that the visits that Joey has made since December [56] 1973 to other homes have been unsuccessful or there were major problems incurred?

A Major problems, no, I don't think so.

Q Okay. Do you yourself have any clinical or psychiatric type of background, training—child psychiatric background, psychology, specifically?

A My Bachelor's degree was in psychology, sociology; I've been to several workshops that have been lead by people who are . . . whose names are well known in the area of . . .

Q But as to any specific long term training or degrees, you do not?

A No.

Q Let me just clarify just one last thing, and that is that since December 1973 in the last approximately two years, you've had eight to ten personal contacts with Joey, is that right?

A Yes, and I will say that these contacts . . . a lot of times Joey has not even been aware of these contacts, that I would just see him and observe him for a few minutes. There was some reason behind this; ordinarily with a child in Joey's position, a child that we would be looking for a foster care placement or considering any other resource or just working with, I would have much more contact than this, but Joey was at Central State, there were many other people involved with him, and it was our feeling that another caseworker, somebody else coming in, [57] would be confusing to him—he knew who I was, he had been told that we were looking, that the agency was helping looking for a foster home; we were not going to promise Joey something that we could not come through with, so I kind of stayed, just stayed away from Joey; he had many questions about why, when and this kind of thing. Betty Harris was in constant contact with him and she handles the type of think that I would ordinarily handle with a child.

MS. LINDBLOOM: Okay, that's it.

DIRECT EXAMINATION BY MR. LACKEY:

Q During the course of the examination you mentioned that at one time you had a specialized foster home allocated to this area, is that correct?

A Yes sir.

Q Was it to Baldwin County or to the district?

A To the district or the region; at that time our regions were a little different, but it was a county area, like an eight or ten county area.

Q And this was a funded position?

A Yes.

Q And you were unable to develop a couple that could fill that position out of this region?

A Yes.

Q Do you know how long you tried?

A We must have had these funds available for maybe a [58] year. We, as I said, it would have been our county and several other counties and if we had come up with a couple in every county, we would have had to decide which would make the better specialized foster home. You know, there was just nothing available for this here in Baldwin County. We thought of taking one of our foster homes and trying to make a specialized foster home out of that home, but we saw later that we wouldn't be able to do that.

Q Did this occur during the period when Joey was in the hospital here or do you recall?

A Yes.

Q Let me see if I understand—you testified that you had a specialized foster home allocated for this region, it was funded for approximately a year, there were approximately eight counties involved, and you all couldn't find anybody to fill that position—would you answer please?

A Yes, I'm sorry.

MR. LACKEY: Thank you; that's all I have unless you want to explain.

MS. ETHERIDGE: There was one other point that I wanted to bring out.

MR. LACKEY: Go ahead.

MS. ETHERIDGE: We have talked about efforts made here in Baldwin County to find Joey a foster home—it's also been considered that Joey might be better off in a foster home outside of Bald-[59]win County because of the situation here with his natural mother, which is traumatic—it's traumatic for her but it's very traumatic for Joey and there has been much speculation and I think kind of a decision that if we could find a resource outside Baldwin County that this would be better all for Joey.

DIRECT EXAMINATION BY MR. LACKEY:

Q Is there any sort of search going on for this type of facility that you know of?

A A specialized foster home would be outside Baldwin County because there would be no resource for that here, and except for saying again that those who are responsible for placing children in specialized foster homes know of Joey's need, and there's just no vacancy there.

MR. LACKEY: That's all I have.

CROSS EXAMINATION BY MS. LINDBLOOM:

Q I have one question—to clarify that—you mentioned there was a slot for a specialized foster care home; let me just make sure I understand—do you know whether it was for specifically Baldwin County or was it for the district of which Baldwin County is a part?

A It was for the district—it was not just for Baldwin County, it was for a home to be developed in that district . . . in this district.

Q And there are eight counties?

A Our districting was different then or either it changed [60] right as that money was taken away, but it was seven or eight or probably nine counties at that time involved.

Q Can you be a little bit more specific if possible on the year, the time this funding was available—was it in 1974, was it within the last year—1975?

A No, it was not within the last year . . .

Q 1974 perhaps?

A I would probably say 1973 1974—not those two years, but say a fiscal year from July 1973 to July 1974.

Q How were you made aware that there was this slot available?

A There was a memorandum sent to us from the state office saying that this money was available.

Q Specifically that the money was available for this district?

A Yes—it was sent to all the county offices . . .

Q Within the district; okay, fine. Who did that memo come from?

A I can't remember; I think the memo probably came from the state office to our . . . to Val Weathers, who was our Social Service Director at that time and she sent the memo to each county office, in her area . . . in her region or her district. That would have been one memo that came from the state office to Val or some notification.

Q And she then in turn communicated it to you?

[61]

A Yes.

Q In that same memo, did either she or in the memo, did they outline what efforts people such as yourself, caseworkers on local county levels should make in seeking

to fill that slot, to find foster parents to fill that slot—were you given any specific instructions as to what to . . . how you might go about recruiting . . .

A I don't think so, just look in our foster homes and to look at our . . . any new applicants that we had, to make whatever efforts we could, you know, we are so badly in need of foster homes here and everywhere, it's just understood that you are continuously looking for foster homes and when you have a program such as this, we also have Emergency Shelter Care Homes, which are . . . provide very short term foster homes, they are specially funded programs that . . . specially funded homes that we only can have a certain number of, and we searched for an Emergency Shelter Care Home and for a specialized foster home we searched rather diligently during the time that money was available, just wanting to have . . . to develop that resource while the funds were available.

Q As far as your efforts within Baldwin County itself, did you contact the existing foster home parents within the county to ask them whether they had any desire to become specialized foster parents; in other words, did you send out any communication to them?

[62]

A No, I did not because I know the foster homes in this county well enough to know that they would not fit into the characteristics or stipulations that these foster homes . . . that a specialized foster home has to meet.

Q The characteristics that you mentioned before when I asked you to define a specialized foster home was the training that the foster parents in that home received such that they would be able to cope with specific needs of a child, am I quoting you correctly or am I getting the gist of your . . .

A Yes, that would be in the definition or in what a specialized foster home is, that's part of the specialized foster home—the foster home here that I spoke of thinking of working this foster home into a specialized foster home, there were some changes in the living arrangement there at the home, some changes in that family that let me know that they could not be a foster home . . . a specialized foster home.

Q Other than the existing foster homes within the county, did you make any special effort in terms of recruitment when you had knowledge of this slot; in other words, did you do any . . . you mentioned like a newspaper article or something like that, anything specifically written during the year that this slot was available through use of the media, or any other method to alert the public as to the slot and what specialized foster care was and the availability?

A I believe there was a news release about specialized [63] foster homes from the state office at one point—I don't remember when that was, there was nothing specific from Baldwin County. What we did at this point . . . during that year we did some radio spots, there was a series of articles, stories that we got from the state office on foster homes, saying if you would like to be a foster home, if you were interested, know of someone else who was interested, contact or refer. If we had advertised just for a specialized foster home, we might have been flooded with requests that we would have to weed out. By just asking for those who were interested in providing foster care, we felt like the best and most potential candidates for specialized foster homes would come forward and we could work into this.

MS. LINDBLOOM: Okay, that's all I have, that's all.

* * * * *

[1]

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION**

(Caption omitted in printing)

The deposition of ARTHUR FALEK, Deponent, taken at the instance of the Defendants; all formalities, including the reading and signing of the deposition, waived before Edward H. Lieberman, Certified Court Reporter, at the Georgia Mental Health Institute, Atlanta, DeKalb County, Georgia, commencing at 9:00 a.m., December 8, 1975.

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[2]

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[3]

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EXHIBITS

Number	Description	Identified
FOR THE DEFENDANT:		
No. 1	Curriculum vitae and bibliography	5
No. 2	"Classification in Schizophrenia"	11

[4]

PROCEEDINGS

Whereupon,

ARTHUR FALEK

was called as a witness and, having been first duly sworn, was examined and deposed as follows:

DIRECT EXAMINATION

BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A Arthur Falek.

Q And where are you employed?

A I am employed at the Emory University, and my laboratory is located at the Georgia Mental Health Institute.

Q And what is your educational background?

A I have a Ph.D. from Columbia University in human variations, studying human genetics.

Q So primarily you're interested in human genetics; is that correct?

A Yes. My background, my qualifications—if that's the direction of the question—are in statistics, human genetics, general genetics, psychology. The reason that it's such a broad kind of a statement about these qualifications—I mean, people are qualified in one field or another, but the basis for the broad qualification is that when I went through for my doctorate, there were no people trained in human genetics. Columbia University didn't know what to do [5] with someone who wanted a degree in human genetics, so they felt the easiest way was to qualify you in every stage of the way, so they went along qualifying—insisting that you have to qualify in these various areas, so the people sitting on my committee were the people at Columbia University who had the qualifications to give a doctorate in each of these areas.

[Whereupon, a document was marked Defendant's Exhibit Number 1 for identification.]

BY MS. KIRKLEY:

Q Would you identify Exhibit 1, please?

A Yes. This is my curriculum vitae, indicating my professional activites, and the other pages are my bibliography—my list of publications.

Q Are those both current?

A Both are current.

Q What is the nature of your present work at GMHI and Emory?

A My present work is research in psychiatric genetics, with particular interest toward early detection of disorders.

Q Particular disorders?

A Yes. One area of interest is in alcoholism and concern with cirrhosis, and we are doing tissue studies, biochemical studies of tissues from human liver tissue, looking for the biochemical variations in patients with cirrhosis versus [6] patients with other liver disorders versus other normal individuals. That's one aspect of this study. Another study is in—we're interested in a study on reproduction in schizophrenia. We're interested in a program in birth defects in general. We have a study with the Center for Disease Control where we're following all newborns in the five county area. We're trying to identify the frequency of various kinds of birth defects in the population. We're concerned with epidemiology. We are concerned about variations in frequency over time, or with particular environmental kinds of situations, and from a genetic point of view, of course, we're concerned about recurrence so that when we give genetic counseling we can give the appropriate kind of counseling to the parents of patients with these various kinds of anomalies.

Q Are you the head of a unit that does research so that you would have some other people who are doing research with you?

A Yes. I'm head of the Laboratory of Human Behavioral Genetics.

Q And how many people work with you approximately?

A Oh, about a dozen.

Q Okay. In your work, have you had occasion to study the reliability of diagnosis in schizophrenia?

A Yes.

Q Would you describe for us, please, and eventually [7] for the Court what your findings have been?

A The diagnosis—The reliability of diagnosis of schizophrenia is somewhat over 50 per cent, and varies between 50 per cent and some 87 per cent, according to various investigators in the field. The issue that interests me was the reliability in schizophrenia versus the reliability in physical disorders, and when you look at the reliability in physical disorders, you find that the frequency of reliability is no better in a variety of physical disorders, from tonsillectomies to cardiac disease to the pap smear, or the diagnosis for cancer of the cervix, as compared with diagnosis for the particular mental illness called schizophrenia.

Q What was your methodology, Doctor, in reaching this conclusion?

A Well, this was really a library review aspect. What we did was to pull all the material from around the world to collect the data in the various languages to be able to make certain that we were talking about—that we had the basis—the data base for presenting the information, because we wanted to demonstrate that with regard to reliability in schizophrenia, it was going in the same direction now as other medical disorders, and that reliability —the direction for this kind of reliability was to improve reliability as time went on.

Q Okay. And have you published the results of this?

[8]

A That's right.

Q Would you tell us the citation, please, Doctor?

A That paper is "Classification in Schizophrenia." It's in the *Archives of General Psychiatry*, published in Volume 32 in January of 1975.

Q All right. I believe you stated that your findings were that the reliability varied between 50 per cent—

A Most of the studies varied in the 50 per cent range to about 87 per cent.

Q Would you explain how that figure was derived, 50 per cent, or what that means?

A Okay. There are three types of studies with regard to reliability that one deals with when one is concerned about diagnosis: one is concerned about the observer agreement—that is, one psychiatrist looking at a patient, and a co-diagnostician and co-psychiatrist making an independent observation, or a psychiatrist making a diagnosis and residents making a diagnosis; or there is consistency over time—that is, a patient enters an outpatient clinic first, and then goes to a psychiatric institution, and then goes to an outpatient clinic—how consistent is the diagnosis from the first stage to the last stage situation; and then there is occurrence in comparable samples—that is, patients in three wards at the same time.

Q And when you reached your figure of 50 per cent to [9] 87 per cent, I believe—

A Well, if you look down the numbers, there are very few that are less than 50 per cent. There are one or two studies—one study, I guess, in each of the categories—where the observer agreement is under 50 per cent range—

somewhere in the high 30's—but most of the studies are with much higher agreement between psychiatrist and psychiatrist or from patients going from an outpatient to an inpatient, or being looked at an inpatient facility over a course of years.

Q The third method, occurrence in comparable samples.

A Yeah.

Q Those look somewhat lower than the other two methods.

A Well, these are frequencies. Those aren't percentage of concurrence. Those are the frequencies of patients found within a hospital setting. It's like three wards of a hospital, or what's the frequency of a psychiatrist, or three psychiatrists, or whatever number of psychiatrists, seeing patients in a ward—what frequency of patients with schizophrenia did they see—and therefore, this is a different kind of number. These numbers, the greater the similarity between the numbers, the greater the concurrence, so that the first study, for example, by Pasamanick, 36,23 and 26 is very high consistency in the frequency in diagnostic categories in the three wards. The second study of the three psychiatrists said, "Okay, what did these three people see," and there's something quite [10] different there in this 29 and 22 and then the 67 per cent, and that's a very interesting kind of study, by the way, because that really is the concern of the approach that was conducted by the group with the U.S.-U.K. diagnostic project. That really was their direction. Why was there this kind of—you have three psychiatrists, and you have this kind of wide variation suddenly occur. So what they did is to start out—the basis for the study—the people

who were really organizing the study started out by developing a videotape method, and sending videotapes of patients, clear-cut schizophrenics, totally questionable kinds of categories—on videotape to groups of psychiatrists in the United States and in England, and they found differences. The most interesting study for me was the one in North Carolina, because in that study, where the psychiatrists were using fairly clear-cut diagnostic schema, the diagnoses of schizophrenia in the United States and with the patients as seen in London and in various other parts of England were very much the same. I think it was London and Glasgow, or something like that.

Q Is the North Carolina study part of the U.S.-U.K.?

A Well, all of these studies became the basis for the U.S.-U.K. study, and the U.S.-U.K. study demonstrates that when psychiatrists are trained in a similar manner, that the frequencies of schizophrenia, be it in London or New York, are the same, rather than at the kinds of extremes, like 60 per [11] and in the low 30's, and they demonstrated this by showing that when they had a trained group of London—of English and American psychiatrists trained by one team of psychiatrists, that these people produced the same frequency of patients from a population which was different from that of a general hospital type of schema.

Q Is this U.S.-U.K. study published, Doctor?

A Yes.

Q Would you just give us the reference to that?

A It's called *Psychiatric Diagnosis in New York and London*, and it's by J. E. Cooper, R. E. Kendell, B. J.

Gurland, L. Sharpe and J. R. M. Copeland and R. Simon, and it's Oxford University Press, London, in 1972.

[Whereupon, a document was marked Defendant's Exhibit Number 2 for identification.]

BY MS. KIRKLEY:

Q Would you identify Exhibit 2, please?

A Exhibit 2 is the paper of "Classification in Schizophrenia" by Dr. Hanna Moser and myself.

Q And when you are referring to the various studies that have been done—

A They are all listed on the references.

Q When we were talking about the different ways of determining reliability, we were discussing Table 3; is that [12] correct?

A That's right.

Q And in your opinion, the first Pasamanick study here indicates substantial—

A —similarity. That's right.

Q And—

A The second one shows that one of the psychiatrists diagnosed a different frequency than the other two.

Q Okay. You did review all the literature; is that correct?

A I reviewed all the literature that I was able to at that time and that I am aware of. We did the World Survey of Literature, so we tried our best to get as much information as possible.

Q And this was just published in 1975; is that correct?

A '75, that's right.

Q So you reviewed all the literature up until that time.

A That's right.

Q And what about the literature with regard to physical medicine?

A Well, the literature with regard to physical medicine shows that the consistency in diagnosis is about the same for physical medicine as it is with mental medicine, with regard to schizophrenia, for example.

[13]

Q Would that just be true for certain physical illnesses, or in general?

A Well, for all those that we could find references in the literature.

Q All the studies that have been done.

A All the studies that have been done. This is not to criticize medicine and say, "Isn't it terrible that's how inconsistent you have been." This is to say this is where medicine is today, and the point of scientific evaluation and investigations of these types is to direct the attention to what we have currently and to see that we can make—make the diagnoses, or improve the consistency in diagnosis. That's the whole point of the scientific issue.

Q What relationship did this study have to your genetic work?

A All right. Well, I really started this study—as you can see, in the beginning of the study, it's talking about the frequency of schizophrenia in the general population, because that frequency has been reported out over many

years, and most psychiatrists have learned that the frequency of schizophrenia in the general population is roughly one per cent, and I wanted to point out where that one per cent frequency came from. And I was most interested to note that when other studies were evaluated, that the frequency was about the same in other investigations as well. There were [14] eighteen studies in the mid-20's—from the mid-20's to the mid-30's—in the Austrian, Swiss, German border areas, and these studies all came to the same kind of frequency conclusion of about one per cent when the data were corrected for age. Schizophrenia is diagnosed—adult schizophrenia is diagnosed in patients usually between 15 and 45 years of age, so we're talking about an age breakdown of population, and when one corrects for age—that is, one removes all cases that are diagnosed earlier than that and corrects for the population that are living through the 15 to 45, so that it can be diagnosed at any time in that period as schizophrenia, and takes as a whole the number of cases over 45 that had been diagnosed prior to that time of life as schizophrenic, then one is really correcting to see how, and increasing the frequency to its uppermost limit. So the one per cent frequency is a fairly high frequency. The uncorrected data ranges about 0.35 per cent, plus or minus a small variance. When one looks at the data published by Yolles and Kramer at the National Institute of Mental Health some years later, one finds that their data, which is on different studies, with a much larger population basis to evaluate, they find that their frequency—uncorrected, they find that their frequency is 0.35, plus or minus a small variance as well. So it was very intriguing to me, who has been talking about genetics and schizophrenia, how consistent the diagnosis has been over the [15] course of time. Now, there has been the problem for a period of

time where, I guess because of the frustration of the psychiatric research community—where there was a broadening of the definition of schizophrenia—what we now know, with the introduction of the U.S.-U.K. studies and the videotape studies and the development of the attempt to computerize diagnostic classification, that the research psychiatric community is tightening the definition once again and going back to trying to refine diagnosis so that one becomes more and more consistent, and I think that's the approach of the scientific community at this point with regard to mental illness. That's what they're doing with regard to manic-depression. That's what they're doing with regard to other kinds of disorders as well.

Q What is the importance of that for your work in genetics?

A Well, now, if one is able to diagnose in a consistent manner, and when you get a frequency for the general population, then one can become interested from a genetic point of view about what the frequency is within families, within twins, within children adopted from families with schizophrenia. Then you can start becoming concerned about the genetic aspects. If the diagnosis is so loose that it varies all around the map, then looking at the frequency of occurrence in families becomes a very difficult and almost useless kind of exercise.

[16]

Q So this review formed the basis for the work you're presently interested in.

A That's right.

Q Did you see, say within the last 15 to 20 years, any increase in the reliability of diagnosis of schizophrenia?

A Well, I think in the last eight years—the last seven to eight years—with the new approach, with the new concern about diagnosis, and the new publications with regard to diagnosis, and the U.S.-U.K. studies, and the computerized kinds of techniques to clarify schizophrenia, that I think that this kind of approach can only improve diagnosis. Obviously, the U.S.-U.K. study showing that one has to train psychiatrists, whether they're in the United States or wherever, in the same kind of classification scheme in order to get comparable kinds of populations for evaluation if an appropriate kind of approach for improving diagnosis—and that, in turn, is exhibited by this publication of *The International Pilot Study of Schizophrenia* of the WHO, which is this publication here, which is really going in the same direction. It's saying, "Okay, this is where we are now. What ought we to do?" Now, the man who was very much involved in this kind of presentation was one of the people very much involved in developing the diagnosis—the U.S.-U.K. study to improve diagnosis of schizophrenia.

Q Would you give us the reference to that?

A This is *The International Pilot Study of Schizophrenia* [17] and it's Volume 1, World Health Organization, Geneva, 1973.

Q What is the substance and summary of that work?

A Well, the substance and summary is a call for techniques to classify by computer analysis and to talk about concordant groups of schizophrenics and evaluate those populations.

Q Your paper on Classification in Schiophrenia is basically a review of the literature.

A That's right.

Q Have you been involved in any studies yourself?

A Yes, I've been involved in studies in schizophrenia since 1949. I was the research assistant and associate of a man named Franz J. Kallmann, and Franz Kallmann was the man who developed the twin study, family method for doing genetic studies in schizophrenia. He was located at New York State Psychiatric Institute, and I was associated with him for 16 years, and left that organization to come here.

Q Okay. Would you just describe what those studies involved and what your work was, and the findings of those?

A I helped with the field work, of course. The kinds of studies that we conducted at the New York State Psychiatric Institute in the Department of Medical Genetics was that we did twin studies and family studies on various mental illnesses—various mental disorders and aging, and in tuberculosis, and we did these studies trying to specify whether or not there [18] were genetic factors in the various types of disorders. My job in these kinds of studies of schizophrenia and manic depressive psychosis was: a) to do family interviews; b) to do the statistical analyses of the data; c) to help write some of the papers; and after a period of time, to develop the studies that were going to be conducted in the department myself.

Q What were your findings with regard to the twin studies and schizophrenia?

A With regard to the twin studies and schizophrenia, what we found was that when we looked at siblings, brothers and sisters of schizophrenics, we found that our frequency rate was between 14 and 16 per cent; when we looked at twins—dizygotic twins—two egg twins—we found that the concordance rate was 14 per cent, so that

we had very similar concordance rates between dizygotic twins and siblings. When we looked at the concordance rate of monozygotic twins, identical twins, we found that our concordance rate, when we corrected for age, was 86 per cent, so that we then reported that there were high genetic—that genetic factors were very significant with regard to schizophrenia. My concern has always been what is the general population rate, because we find the various numbers in terms of the general population. That's the reason I kept going back and being concerned about it, and I wanted to get this off my back sort of, I think, because it was bothering me; what was the general population rate, and where [19] did that one per cent frequency rate come from—that's bothers me for years. Being able to resolve that problem is just one issue that makes me feel a little bit better about the data that we've been publishing. Now, this kind of information about genetic factors in schizophrenia has now been confirmed several times over. And the more recent studies are those showing that in the families in which the children are adopted out at birth, when you compare these children adopted out at birth and compare them with the children at the home of the families adopting them, you find that the frequency of schizophrenia is remarkably higher than expected by chance. So they're saying there's much evidence now from family studies, from twin studies and from the adoption studies demonstrating that genetic factors are operable in schizophrenia.

Q And you were saying the occurrence of schizophrenia in the general population is somewhere slightly less than one per cent; is that right?

A Well, the corrected data is about one per cent; it's the frequency that's been reported out, yes.

Q And then for siblings and two egg twins, it would be about 14 per cent.

A Yes.

Q And one egg, identical twins—

A Now, those are the corrected numbers. If you look at the uncorrected numbers, the data suggest that for siblings [20] the frequency is ten per cent; for two egg twins, the frequency is ten per cent; and for identical twins, the frequency is 50 per cent. Similar kinds of numbers are also shown in looking at one or two parents with schizophrenia: one parent affected, your frequency is about ten per cent; and two parents, the frequency is somewhere between 40 to 50 per cent, but closer to the 50 per cent mark.

Q Did you conduct similar twin studies with regard to depressive psychosis?

A Yes. There is a paper by Franz Kallmann on manic-depression and schizophrenia—manic-depression as well as schizophrenia.

Q Did you conduct the study for him on that?

A I was one of the people going out, and one of the people doing the statistics—certainly I had a lot to do with the statistics.

Q Do you remember the findings of that study?

A The concordance rate for monozygotic twins ranged close to 100 per cent with regard to the population, and the concordance rate for dizygotic twins, if I remember correctly, was somewhere around 23 per cent—22 or 23 per cent.

Q And what would the occurrence be in the general population?

A Lower than the frequency for schizophrenia. From a population point of view, there's a lower frequency of [21] individuals in the general population.

Q Okay. That's all the questions I have.

[Brief recess.]

CROSS EXAMINATION

BY MR. GOREN:

Q Doctor, have you had any training in child psychiatry or child psychology?

A No.

Q Have you had any training in general psychiatry or psychology?

A In general psychiatry, I had to take two courses in the New York State Psychiatric Institute in order to be able to work with the population in the cases I'm involved in. In regard to child psychology, while I did not take specific courses in child psychiatry, I was involved in the studies with Loretta Bender and with Franz Kallmann in childhood schizophrenia, the early study that was published in the early 60's—no, the late 50's I believe—in childhood schizophrenia, so I did have that kind of involvement. We were trying to talk about schizophrenia versus autism, and things like that.

Q Okay. How long did those courses in general psychiatry take?

A Well, I cannot tell you precisely. The courses I was involved in involved receiving lectures, and becoming involved in psychiatry at the New York State Psychiatric [22] Institute all the way through my doctoral program, and the doctoral program lasted from June of '49 to 1957,

so it was a long time in growing and birthing, because they didn't know what to do, and so Franz Kallmann insisted I be trained in psychiatry. Joseph Zubin, who is a very well know clinical psychologist in abnormal behavior psychology was chief of abnormal studies at the New York State Psychiatric Institute. He insisted that I be qualified in psychology, so I had to get a qualification in psychology as well as being trained in these kinds of specific psychiatric fields, so I was constantly being pushed by one or the other members of the Ph.D. administrative team to become qualified in their particular area of knowledge, so they would have someone who would work in a mental health, genetics type of thing. It was new entity.

Q Okay. You don't have a medical degree.

A No.

Q Your degree is just in genetics.

A In human genetics—in human variations, which was really human genetics as Columbia University was trying to push this degree out.

Q Okay. Have you ever personally participated in the diagnosis of children?

A Not really, no.

Q Okay. Do you participate, or have you ever participated in decisions to institutionalize children?

[23]

A No.

Q Does your study of classification of schizophrenia and diagnostic reliability also extend to diagnostic reliability of other classifications of mental illnesses?

A It does not. It was aimed particularly at schizophrenia.

Q And you did not study other diagnostic classifications.

A No, I did not.

Q Are you aware of the percentages of children who are presently in Georgia state mental institutions in the various diagnostic categories?

A No.

Q So you don't know if it's a minority of children in Georgia's mental health institutions who have schizophrenia.

A I do not know.

Q Do you think it's possible for psychiatrists to err in diagnosing a child or adolescent as so seriously mentally ill as to warrant his or her institutionalization?

A Yes. I think, as demonstrated in this paper on classification, there is a frequency of misclassification, absolutely.

Q Okay. So errors can occur.

A False positives, and false negatives as well.

Q Okay. And the orientation—

A But that really—I think it's not only in regard to [24] mental illness. This occurs throughout medicine.

Q Are the consequences different?

A The consequences are different according to the disorder that's being diagnosed. For mental illness, it may be improper treatment, which can maintain the patient at the same level as the disorder. Of course, various other

kinds of disruptions for misdiagnosis with regard to cervical cancer—it could have far more direct implications with regard to survival.

Q Okay. In regard to the orientation and training of psychiatrists, does their orientation and training have any effect on their diagnosis of mental illness?

A Absolutely. Different types of orientation result in psychiatrists to diagnose a broad or a narrow view of schizophrenia, and my concern has been with this broad kind of diagnostic schema, and opting for the more narrow diagnostic schema, which is being returned to now.

Q Okay. Depending on the particular psychiatrist's orientation or training, is it possible that persons from two different backgrounds—psychiatrists from two different backgrounds who evaluation a child, that one could diagnose a child a schizophrenic and the other would say that that child is not schizophrenic?

A Surely. But he might say that this child has an emotional disorder, but not schizophrenia.

[25]

Q Okay.

A I think if one wanted to talk about diagnosis of emotional disorder versus non-diagnosis of emotional disorder, I think one would get a greater consistency among psychiatrists, whatever their background, because the emotional disorder category is broad enough to include many types or several types of illnesses, while the diagnosis of schizophrenia, particularly childhood schizophrenia, becomes a far more definitive diagnosis and requires far greater specificity with regard to the kinds of criteria to be included in the diagnostic schema.

Q But even within the same classification of mental illness, is it possible that doctors with different orientation and training would disagree in the severity of the illness?

A That's another question. You're talking about severity.

Q Yes.

A Yes, with regard to severity, absolutely.

Q Okay. In a like manner, are there also different schools of thought in psychiatry which would lend a doctor to one diagnosis that may be different from a diagnosis of someone who is schooled in different thought?

A That's true.

Q Is it possible that the context of a psychiatric evaluation would have an effect on a diagnosis? Let me be more specific.

[26]

A Yeah. Thanks.

Q In a particular setting in which an evaluation takes place, is it possible that the person doing the evaluation may make his diagnosis in accordance with the setting? Let me give you an example. If you walk into a room and you see a book in the waste paper basket, the context in which you see that book might lead you to believe that book is not valuable; however, if you see a book locked away in a case, you might think, in that context, that book is valuable. Okay. In the same manner, when you're evaluating a patient to determine if they have mental illness, does the setting in which the interview takes place, or the setting in which the evaluation is made have an influence on the diagnosis?

A I don't know of any studies demonstrating one or the other side of that kind of an answer. I would hope that it would not. I would assume that there are biases, that individuals have biases, but I would hope that whoever is evaluating the individual and not the setting.

Q Are you familiar with Rosenhan's *On Being Insane in Insane Places?*

A Is that the study published in Science—

Q Yes.

A Of patients that came through with a diagnosis of schizophrenia?

Q Yes. Are you familiar with that?

[27]

A I remember reading the study. I have not read that study in several years. The thing that I do not recall about the study is how long did the individuals remain in the hospital after they were institutionalized.

Q I can show it to you, but if you're not that familiar, we won't go into it.

A I'm not really that familiar with it.

Q Does a single unstandardized interview, the results of which may be augmented by psychological testing, present an adequate sample of a person's behavior from which to make a diagnosis?

A If it's a single, unstandardized interview, which means that it could not have been—could not have been conducted by anyone who is trained, yeah, absolutely.

Q Okay. You're assuming that it could not be done by anyone who was trained.

A I'm assuming that it better be done by someone who is trained. I have much concern about this—about the training—and I think the whole approach of this book here is that with training, you have consistency.

Q Okay. Is it possible that psychiatric judgments may also be influenced by the socioeconomic background of the doctor and the patient?

A It's possible.

Q Is it also possible that the doctor's own personality [28] or value system or self-image or personal preferences can affect a diagnosis?

A That's right, it's possible. You would hope that somewhere in medical education that people learn how to deal with this kind of an issue. I know that people are concerned about this issue, and really very much involved. I know that Dr. Holland, for example, goes through the Grady unit and goes through these units looking specifically for this kind of bias, whether it's conscious or unconscious, because of his concern about it.

Q Do you know if anybody does it in any of the other state institutions?

A I do not know that.

Q The superintendents of the Georgia Mental Health facilities testified that generally they use the Diagnostic and Statistical Manual Number 2 in labeling children and adolescents. Are you familiar with that?

A No.

Q No what?

A No, I'm not familiar with that. I know the DSM. I don't know the contents of these various texts.

Q Okay. Are you familiar with any studies involving criticisms of this manual?

A No.

Q Are you familiar with any of the work of a Dr. Robert [29] Spitzer?

A Yes, very much so. You're talking about his computerized diagnosis.

Q Okay. Well, first of all, I want to talk about a recent paper that he published concerning clinical criteria for psychiatric diagnosis in DSM 3. Are you familiar with that?

A No.

Q Okay. Let me perhaps summarize this for you and ask you if you agree with his point of view in this paper. Let me give a cite for this article. It's in *The American Journal of Psychiatry*, Volume 132, Number 11, November, 1975. Okay. Dr. Spitzer's argument in this article—he describes as having to do with the "well-known generally low degree of reliability of current psychiatric diagnostic practices," and he attributes the sources of this unreliability to four variances: subject variance, occasion variance, information variance and criterion variance. Are you familiar with any of those terms?

A I understand what they mean, yes.

Q Okay. Let's talk particularly about criterion variance. Could you explain what that means to you?

A That the criteria for the diagnosis of the particular disorder that the physician was involved in—what the differences in the criteria were between different physicians.

Q Okay. And do you have an opinion as to how criterion variance may affect diagnosis?

[30]

A Well, with regard to schizophrenia, that issue is taken up in the discussion about the methods of classification and in these studies that were conducted—let me go find it—in the observer agreement and disagreement, because that would be criterion variance among trained interviewers.

Q Okay. Is criterion variance a big factor in reliability of diagnosis of schizophrenia?

A I think it's an important factor. The data suggests that what he said—there is one study in the United States showing average group agreement of 37 per cent. The other four studies range from 53 to 80 per cent, so there is variation based on—certainly, there is no correlation of 100 per cent, or anywhere near that, between one observer and another—trained observer.

Q Okay. On direct examination you were saying that the frequency of reliability of diagnoses—you said at first it can be around 50 per cent, and then could go up between 50 and 85 per cent.

A Yes. That's these numbers.

Q When we're talking about in the range of 50 per cent, are you saying that a diagnosis—that in having psychiatrists agree on a diagnosis, that half the time they're going to agree and half the time they're going to disagree. Is that what you're saying?

A That's 50 per cent, yes. Now, the whole aim of all [31] of these various studies is to deal with this question and to improve on diagnosis.

Q There's seen a need to improve on diagnosis?

A That's the whole point of all medical investigation is to improve on the data that you have now to have it more consistent and more useful.

Q Okay. So the general state of diagnosis now needs improvement; that's what you're saying.

A In all phases of medicine.

Q Okay. In your paper that was introduced into evidence, "Classification in Schizophrenia," which is Defendant's Exhibit Number 2, you state on page 63 that there is some evidence of a high frequency of disagreement in diagnosis.

A That's right.

Q Could you explain what that means specifically?

A You'll have to give me the quote. All right. The statement before that reads, "Almost all of the data suggest, therefore, that with regard to diagnostic concurrence in schizophrenia, reliability is better than chance. There is, however, some evidence of a high frequency of disagreement in diagnosis." That's just to reinforce the statement prior to it, but to say that there is this kind of variation being shown, even though the diagnosis is better than chance.

Q Okay. Are you familiar with the term Kappa coefficient?

A No.

[32]

Q Again, back to Dr. Spitzer. Are you familiar with Dr. Spitzer's article called "Quantification of Agreement in Psychiatric Diagnosis?"

A No. I know Spitzer's material on the computerized mental status examination.

Q This article that I'm referring to is published in *The Archives of General Psychiatry*, Volume 17, July, 1967, and that describes what he says is the Kappa factor. And just to summarize again what his point is in this article, it is that trying to quantify diagnostic reliability, there is a chance factor that has to be accounted for, and the Kappa factor is what he has used to take into account the chance factor in diagnosis. Okay. Did you incorporate this chance factor in your studies?

A No, I did not, because the only—what we looked for in looking for the reports was to have papers—I mean, to look up all papers that were published with regard to diagnosis and consistency of diagnosis in schizophrenia. If it did not deal with that issue, then we did not become involved in the paper. Since this paper is not particularly addressed to schizophrenia, and not addressed to this kind of an issue directly, I did not have the opportunity to read that paper.

Q But isn't it possible that in determining reliability of diagnosis for schizophrenia there—just by chance, psychiatrists are going to agree?

[33]

A The other side of that statement is the findings, and when you go and look at the 18 studies that were published in the 20's and 30's—in the 20 studies that were published in North America, Europe and Asia talking about schizophrenia—not talking about those other 18—they had the same age uncorrected morbidity risks, so whatever these psychiatrists were doing, they're doing it in the same manner, and that's the phenomenon that

so impressed me, because these are different studies than these 18. So there are 38 studies demonstrating consistency.

Q But the studies also didn't take into account the chance factor; is that correct?

A They were just reporting out what the frequency of schizophrenia was in their population under investigation.

Q Okay. Let me backtrack a little. Could you tell us when your study was ready, as opposed to when it was published?

A All right. The original draft of the paper was completed for October of 1973. It was brought up to date before publication in '75.

Q Are you familiar with the types of physicians that are employed by Georgia to work in their mental institutions in regard to their training?

A In regard to their training, no.

Q So you don't know if they're all trained in the same place by the same people.

[34]

A I would assume that they weren't all trained in the same place. That would be an easy assumption.

Q Okay.

A Let me make a statement to follow that one. I think the most important thing about the diagnostic classification is that they present these with the basis for the diagnosis in the medical records of the patient. That's the most important kind of thing.

Q Do you know if they do that?

A Yes. In most medical records one finds this kind of information.

Q Okay. But you don't know from your own personal knowledge this is what's done in Georgia in all of Georgia's mental health institutions.

A No. But I'll tell you one thing that we do know, and it's a peculiar kind of entity. It intrigued me, and I started out with a negative and ended up with a positive. Two psychiatrists, whose names I cannot recall now, and myself went to Milledgeville and did a review of classification for schizophrenia, because we were interested in doing a study along this line, and found that in regard to the classification, there was information in the medical records upon which to base a diagnosis. My concern is is just schizophrenia written across the face sheet of the medical record and is that the basis for the diagnosis, and I was impressed that it was not.

[35]

Q Did you in fact see the records of any children or adolescents?

A My problem is with adolescents, because we weren't looking for children in this study. We were looking for adult schizophrenia. We must have examined some records of individuals 15—you know, in the middle to late teens.

Q But no children.

A No children.

Q Okay. Can you give an opinion as to frequency of reliability which you have described in schizophrenia as compared to transient situational disturbances?

A Absolutely not.

Q You're not familiar—

A I don't know what transient situational disturbances are.

Q Are you familiar with the diagnostic category of unsocialized aggressive reaction of children?

A No.

Q Are you familiar with the diagnostic category of hyperkinetic activity of childhood?

A I'm familiar to the point of having heard it, but I wouldn't want to say I'm familiar more than that.

Q Are you familiar with the category of adjustment reaction of childhood?

A Just to the point of having heard it. I've never done [36] any collection of data or examination of material.

Q Okay. Doctor, one thing in relation to your comments on the involvement of genetics with schizophrenia, what gene can that be found on?

A Well, a geneticist would not view genetic factors in schizophrenia by saying which gene would it be found on. There are 10,000 to 100,000 genes on a chromosome. There are 23 sets of chromosomes. One set is the sex chromosome in the human. There are several investigations, in fact, looking at that linkage with regard to schizophrenia, and there are several studies forthcoming—Elston's study in North Carolina, and the other one—Bartanian, V-a-r-t-a-n-i-a-n (spelling), from Moscow—suggesting that there is linkage between schizophrenia and some other factor. It was very interesting, because this was a presentation by two of these men in a meeting that I had the good fortune to organize in Paris at the International Congress of Human Genetics in 1971, and both these men read

from prepared texts, and each one reported the possibility of linkage, demonstrating linkage between one well known genetic factor and schizophrenia.

Q Okay. Is our state of knowledge in regard to the genetic linkage in schizophrenia complete?

A Oh, no. Just a beginning of the investigations.

Q Okay. Doctor, what I would like to do at this point is just read to you a description of a disorder and ask you [37] your opinion as to what that description—what category—

A I would not consider myself qualified to make diagnoses, and I would not diagnose this. I'm a geneticist involved in mental health genetics, and if anyone were to buy my diagnosis, I would think that they were in a very bad fix. I'll not do it even with regard to Huntington's Disease, where I sit on the international commission.

Q Okay. Then I have no further questions.

MS. KIRKLEY: I have no questions.

[Whereupon, the above-entitled matter was concluded.]

CERTIFICATE

GEORGIA)
)
FULTON COUNTY)

I, Edward H. Lieberman, Certified Court Reporter, do hereby certify that ARTHUR FALEK, Deponent, was by me first duly sworn and the above, pages 1 through 37, is a true and complete transcription of my stenographic notes taken at the said proceedings and was reduced to typewriting by me personally.

I further certify that I am neither of kin nor counsel to any of the parties, nor am I financially interested in the matter.

WITNESS my hand and official seal at Atlanta, Fulton County, Georgia, this the 10th day of December, 1975.

/s/ EDWARD H. LIEBERMAN
EDWARD H. LIEBERMAN

[SEAL]

Supreme Court, U. S.
FILED
AUG 15 1977
MICHAEL RODAK, JR., CLERK

VOLUME III—Pages 718-951
APPENDIX

IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

APPEAL DOCKETED MAY 21, 1976
JURISDICTION NOTED MAY 31, 1977

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IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

[1]

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

The deposition of DR. JOHN PATON FILLEY taken before Phillip Roger Scott, Certified Court Reporter, commencing at 9.00 a.m., December 10, 1975 at State Judicial Building, Atlanta, Georgia.

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[2]

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[3]

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PROCEEDINGS

MS. KIRKLEY: The stipulations are that all objections, except as to the form of the question and responsiveness of the answer, are reserved until the week after filing when we will file objections in writing.

Whereupon,

JOHN PATON FILLEY

was called as a witness and, having first been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KIRKLEY:

Q Would you state your full name for the record.

A John Paton Filley. Paton is (spelling) P-a-t-o-n.

Q What is your profession?

A I'm a physician and psychiatrist.

Q And, where were you educated, Dr. Filley?

A I went to Yale University for my undergraduate education. Yale University School of Medicine, medical school. Interned in pediatrics at University of Minnesota Hospital and did two years of general psychiatry and two

years of child psychiatry training at North Carolina Memorial Hospital.

Q Are you a Board certified psychiatrist?

A I'm Board eligible.

Q You're Board eligible.

[5]

A I have the training requirements and experience requirements.

Q For both general psychiatry and child psychiatry?

A Yes.

Q But, you have not received certification in either?

A That's right.

Q Is that correct?

A (Nodding head affirmatively)

Q Where was your training in child psychiatry?

A At North Carolina Memorial Hospital which is training center of the North Carolina Medical School.

Q When did you complete that training?

A Completed training in 1957.

Q And, what employment have you held since that time?

A I was on the faculty of the child psychiatry program there at North Carolina Memorial for one year and then went to the School of Public Health, University of North Carolina where I was faculty member and head of the department of mental health for 16 years until I left last summer to come here to Georgia.

Q And, so, you've been here for about—

A Almost a year and a half.

Q And, again what were you the head of?

A I was head of the mental health department for 8 years and then a faculty member in the School of Public Health.

[6]

Q What did that position involve? What were your duties there?

A The program of the department was addressed to primarily the teaching of students in the school of public health about issues related to mental health, aspects of the field, the development of the field, the approach of mental health in trying to deal with problems on a total community basis.

Part of the time our program was for general public health students. During the latter years of the program we had a specialty program in mental health; and we were taking students and training them for masters and doctorate degrees in public health and major in mental health.

Q Did you teach any medical students?

A Only very occasionally was I involved with medical students. Many of our students in the School of Public Health were physicians doing post-medical training.

I supervised residents in child psychiatry for a number of years in therapy and became involved in seminars and so on with the community psychiatry program. We had a reciprocal relation between our program in public health and community psychiatry.

Q Have you ever practiced psychiatry privately?

A During the years I was on the faculty of the School of Public Health I kept a small amount of private [7] practice going all the time.

Q Do you have any idea what your average case load was?

A Small, I carried 2 or 3 or 4 patients at any one time.

Q And, what are the responsibilities of your present job?

A In general to oversee and direct the development of child and adolescent programs in the mental health field for the State of Georgia. It's stimulating, directing, providing research education. Looking after budgetary considerations; working on the development of the general program of the Division of Mental health with particular reference to applications to child and adolescents. I get involved in division committee activity. I've been on the division committiee on development of information system, the committee on the development of confidentiality policy, division committee on the development of training policies.

Q What's the official title of your current position?

A I'm Director of the Office of Child and Adolescent Mental Health Services, Atlanta Division.

Q And, could you describe please the present state program for children and adolescents in the Mental Health Division.

A As is generally true across the country, it's lagging [8] somewhat behind general adult mental health at this point. Within the framework of the division we intend to have a unified system of services that includes hospital and community services. We have hospital services in 7 of the 8 regional hospitals and are working towards getting services in the 8th. We have some representation of child and adolescent services in all 34 catchman areas in the state at the community level. These vary from very

nominal, a few staff in mental health who work with children to quite well developed programs in some of the areas with a sizeable staff whose responsibility and whose child and adolescent services are quite extensive.

Q In the present system what are the criteria for hospitalizing children in a regional hospital?

A The intent has been when in the judgment of the community program a period of hospitalization would be the most appropriate form of care. We haven't arrived at that point fully yet. We still get patients who are referred directly to the hospital by various people from the community and sent there by judges and so on without recourse through the community.

We're significantly increasing the extent to which the referrals do go through the community program. When at the discretion of the community program there's some reason in the case that hospitalization would be appropriate at that [9] time, then he goes to the hospital.

Q I realize this is a very broad question, but when you say, "Hospitalization is the appropriate treatment," could you be somewhat more specific about the kinds of situations in which hospitalization becomes appropriate, what the family situation might be, why hospitalization is preferrable at that time in the child's life.

A It can be quite a variety of circumstances that can make it appropriate for a child to be hospitalized. One would be a very acute, severe degree of disturbance. The child's behavior is quite out of control, and he needs to be in a contained environment until some stabilization is achieved through medication, through program and therapy and so on that brings about a greater degree of capability on the child's part to function within normal controls.

Other situations, due to social circumstances the child's interaction with his parents may be in sort of a vicious circle pattern where it's getting worse and worse; and the parents are not able to change or interrupt this vicious circle; and a disturbance builds. It may be appropriate to hospitalize the child as part of breaking that cycle and achieving a more stable relationship.

The broad general statement would be that these would be the two major conditions in which we say hospitalization is appropriate.

[10]

Q You described—

A To the extent that one other step, the child who is not in his own familiar home, the child has been taken into custody and so on. Very often in that situation there is less capability of the social group to deal with the child. A natural family is apt to be more tolerable of this disturbance than foster parents. Then, the social situation breaks down; and as a way of trying to get some usability in the situation and enable the child to return and function in the community, it may be appropriate to hospitalize the child.

Q You described the first situation as where there was an acute problem that required hospitalization. Would you say that was an emergency admission?

A We tend to use emergency admission as one which within a matter of hours, less than a day, a person ought to be gotten into the hospital because there is some serious risk for the child. The child is running away and getting into a very hazardous situation, violence where there might be danger and so on. So, we tend to think of emergency in those terms.

Many of these situations might be tried in the community basis, in a community program for a number of days or even a couple of weeks before a decision was made that it couldn't be managed in that way. So, even in that first category where it's fairly severe disturbances, it wouldn't [11] always be handled as an emergency admission, say, within 24 hours.

Q Is there a policy that treatment should first be tried in the community and in the home prior to hospitalization?

A There is a policy that says a judgment should be made; if possible, treatment should be tried in the community. I don't see and I wouldn't promote a policy that would say it should always be tried first. A clinical judgment in this case, as I see it, the child from the first contact, the first evaluation shows the most appropriate treatment as hospitalization.

—Q Do you have any written policies that state what you've just expressed as in regard to standards for hospitalization?

A Not specifically in regard to children and adolescents. There's a statewide policy. We have some general policies and divisional policies; and they state things of this general sort; and those are applicable to the child and adolescent programs. But, we don't have specific policies at this time.

Q Do you do training programs for mental health professionals in children and adolescent programs?

A Yes, we were fortunate in being able to identify some funds for the last fiscal year, fiscal '75. We did five statewide training programs of personnel in child and [12] adolescent programs.

Q Give—

A We're less able to do that financially this year. We've just finished one yesterday that was not so much a

training program as a working conference and the development of plans for child and adolescent services on a regional basis. We're anticipating conducting a training conference on the rights of children in the mental health system in January.

Q In training sessions such as these do you discuss the standards for hospitalization and the use of community resources when appropriate?

A Yes, there are many discussions around these sorts of issues. Child and adolescent services has a clearly differentiated focus of service. They have only been in that status since my office was created less than a year and a half ago. There has only been specific funding identified for the development of child and adolescent programs in communities for two and a half years in the State of Georgia. And, when we started the training conferences, last year was really the first time that people had begun to get together outside of their local programs very extensively. And, so, we've been through a process over the last year and a half which has been a great deal of work, trying to work out better and more functional relationships between community [13] programs and hospitals and guidelines on which services belong in what place, how to more effectively work out transfers between parts of the system. It has been a very significant issue and has been discussed recurrently.

Q Have any written statements or policies come out of these sessions yet?

A Not general statewide ones. Our focus has been one of central effect with local autonomy. And, there have been a number of working agreements and so on that have started out of these conferences. People have gone back and worked in their own region between the hospital and

community programs various policies and region agreements and so on of how they would function. But, no statewide statements of that sort.

Q Are there differences among the 8 regions which require this kind of local approach?

A Very considerable differences. Atlanta Regional Hospital serves 10 almost entirely metropolitan catchman areas. They do reach out a little bit into the non-metropolitan areas out in Douglas County, for instance, which I guess is still part of the standard metropolitan district although it gets quite rural. But, southeast Georgia, the Savannah Region has 2 huge catchman areas that are extremely rural and a third which is largely rural and only one metropolitan.

These require different approaches in how you reach [14] the people and how you place facilities close to them and resources you have to call on and so on.

Q So, you have worked mostly in outlining the general approach and helping the different regions—

A Develop their own perspectives, yes.

Q Is part of the standard for admission of children to the hospital on the application of their parents or guardians that they're dangerous to themselves or others?

A I would say that is a fairly rare thing for children. There are certain examples where a child is excessively aggressive and he's dangerous. Or, has a pattern of running away where he could easily get himself into situations where—that are dangerous to himself. Rarely do we see a child who is suicidal. It occurs, but it's not a common danger. So, the frequency for that kind of condition for hospitalization is probably less with children than it is with adults.

Q And, if the children are not dangerous to themselves or others and excluding for a minute that type of admission to the hospital, when in the professional judgment of the psychiatrist especially in the state system is hospitalization indicated?

A You could almost take the word dangerous and translate it somehow—when the child-parent interaction for whatever reasons, whether it's some factor in the child that may be unavoidable or some pattern of interaction the parents [15] and child have gotten into, is thoroughly blocking his development, so he's not progressing. This can be very dangerous to the child's life situation, although it's not acutely a hazard to his life; but, a significant disruption of a progressive growth oriented child-parent interaction, we would view as quite a dangerous thing in the longer perspective of the child's life. That would be one of the major considerations.

Q Is it important in your opinion that a child be given psychiatric treatment at that stage rather than waiting until it becomes eminently dangerous?

A We would like to become involved earlier than that, if at all possible, when the pattern may have started developing. This is one of the reasons we emphasize as much as we're able to outreach programs. We make contacts with school teachers and other people working with children in the community, so as early as possible there can be an identification of some insipient problem and hopefully some kind of intervention then. That may not be in the form of psychiatric treatment. It's more with the teachers or with the social workers or parents to try to interrupt the pattern which is building.

Q What is the basic reason for the expansion of services to children and adolescents?

A Well, the basic reason for the expansion is because, [16] as we have come to see the situation, it appears that provision of these services can be helpful to children and their families and can make significant differences in how their lives progress and be more effective and satisfied people. And, we're not doing nearly enough of it.

The child and adolescent services proportionately are, as I said earlier, quite a bit less developed than general adult services. I did some figuring a year ago on the basis of the 1974 out-patient statistics; and there were, I think, catchman areas in the state that were providing roughly proportionate services in the terms of the size of child and adolescent population, which would say we ought to be providing about 35% of services to children and adolescents. Actually, in many of the catchman areas it was one-tenth or less as much service for children and adolescents as for adults.

Q Is one of the reasons for expansion the early intervention might prevent problems that later in adult life would become more dangerous?

A This is still one of the hypotheses we're working on, not that it's really documented or proven. There haven't been enough of these services or long enough to really know. That's a problem with social experiment; when you try to do something of a major sort of a change in society, it's years before you know what's really done. [17] I think there are sufficient reasons to believe that it's an appropriate direction to be going with that intent. With the intent that intervention in its early stages can reduce the difficulties later. But, I'd say it's still in a stage of a hypothesis. We don't have sufficient documentation to stand on absolutely.

Q I'd like to talk for a few minutes about diagnosis in children and adolescents. And, we have gotten all the statistics from the 7 regional hospitals and the certain categories of mental illness that show up that will perhaps be helpful if you describe what those mental illnesses involve.

The first one is schizophrenia.

A Schizophrenia is a complex idea in any mental health field. It has—The term has been applied to a variety of situations in children; some of which for, say, an adolescent child might be quite closely analogous to what we call schizophrenia in adults. The word is used with younger children specifiying childhood schizophrene, but the picture is quite different.

Childhood schizophrenia is diagnostically what we use for some conditions in which from birth the child is one to which the parents can't form a close relationship. The child is in a variety of ways less flexible. The child is sometimes physically even rigid. You pick the child up and try to cuddle it, and he's just stiff. In other ways when [18] the parents try to interact with the child, they don't get the responsiveness. He is less responsive than normal children. And, some of these children, we usually don't see them until their a year and a half, two or three years old. The parents give a history of the child having been unresponsive, stiff, untouchable almost from birth.

Now, in other circumstances we see children who may have developed apparently quite normally through say the stage of beginning to learn to talk, 15 to 18 months; using some words and then for some reason the child stops using words and becomes more and more withdrawn from the usual, expectable behavior of a child

of this age, and may get further into a situation where he goes about his activities during the day maybe in ways that show no significant difference in human beings and physical objects. He treats people as if they were objects, and he doesn't show a difference. He has not somehow further developed those patterns of functioning that say a person is something unique; and you respond to it one way; and you respond to chairs and tables in other ways. And, such children may get into patters of repetitive head banging and very highly repetitive activities. We refer to this as autistic. We're saying that the child is contained within himself and involved with his own inner processes, rather than sensitive to and responsive to the processes going on in the world around him.

[19]

There are several patterns of this sort that we lump together as childhood schizophrenia. We say that in some sense they are analogous to what we see in adult schizophrenia.

In the long run we may find that it is a very different condition. The notion of common path comes up in a lot of notions. There may be a variety of things that have led to it. But, there are some things about them that are similar. In this case, the failure to interact with the surrounding world with the usual sense of reality of what the world is. Autistic children are not interacting in a realistic way with the world around them. The conventional notions of reality, just as an adult is hallucinating and expressing delusionary ideas, he's not interacting with the world in a realistic way. But, that analogy leads to the use of the same term. It may not be the same condition.

Q Is autism—

A Autism is within the category of childhood schizophrenia.

We also speak of the symbiotic child who has a very special and limited social limitation, intense interaction with the motherhood figure. When the child's behavior becomes very severely disorganized when he is removed from that one interaction, then it's not a usual development of social interaction, although there is a limited situation with that [20] one person.

Q What about when you get to adolescents with schizophrenia?

A The diagnosis of schizophrenia in adolescents is much closer to the diagnosis used in adults. It's based on typically on evidences of a distortion of reality and thought processes and changes in affective behavior to a degree when the usual ups and downs of mirth and sorrow and fear and so on, just sort of a steady unresponsiveness. But, in adolescents we would see delusional thoughts that would be definable; hallucinations is among the indicators that would lead to the diagnosis of schizophrenia.

Q Another major mental illness that appears from the records is adjustment reaction of childhood and adjustment reaction of adolescents. Would you describe what those are?

A In child mental health almost everything that has been done started from people who worked with adults and then began working with children in trying to see how to move the concept in mental health to apply to children. It doesn't work. Just taking notions of adult mental health and applying them directly to children just doesn't work.

People begin to see youngsters who might show quite significant evidences of disturbance which seem to

be very much related to their developmental stage, where they were in their growing up processes and when observed over a [21] period of time would resolve themselves in some sort of way over a period of time. Sometimes a fairly short period of time.

And the developmental disturbances of childhood or adolescence, there are ways of trying to characterize those. Occasionally, particularly in later adolescence we may even see something for a period of days or a week as the manifestation of a psychosis or schizophrenia but resolves itself fairly quickly.

More characteristic what we see is a very aggressive, intense, aggressive response, withdrawn response, a variety of different behavioral patterns. In effect the statement is a prognostic one. It's an effort on the part of the diagnostician to say, "As far as I can judge, putting all the picture together, the behavior I see and the history I gain, the evidences I see of the parent-child interaction and so on, this is a condition that I predict will clear up with not too much intervention." I think again it's somewhat hypothetical to say that when a condition like this occurs a variety of outcomes can follow. And, intervention at that time is intended to see that the outcome is a reasonably healthy, progressive one. It may be acute manifestations of the adjustment reactions may disappear with the child settling into a more fixed behavioral pattern of overt rebellion or of submission or something of that sort, which probably would [22] not be a healthy or as healthy an outcome. So, intervention is designed to try to assure when the expected resolution occurs, what comes out will be a reasonably good one for the child's continuing development.

Q You mentioned one of the symptoms might be

intense aggressive behavior or manifestations of what looks like schizophrenia. Are there any other kinds of behaviors or moods that might appear for a child who has been diagnosed as having an adjustment reaction?

A Yes, the child could just be showing a lot of anxiety. This could be a nervous mannerism, overt anxiety, profuse sweating. Probably not in a child much under adolesence would you see that sort of reaction. It's more typical as the child gets older. Withdrawal, excessive fantasy involvement, imaginary companions, almost any kind of behavior that a child is capable of can appear in excess.

Q What about depression?

A We see very little overt depression that we can compare well with depression in adults in children before adolescence. You begin to see some in adolescent children. I've seen, I guess, in my entire career one child who was probably at the time 10 or 11 who was overtly suicidal; and he took a rifle and managed to put a bullet through his shoulder. But, young children don't—Well, their capability to be depressed seems to be a developmental thing that hasn't [23] arrived.

Q As we've discussed and you've mentioned some differences between children and adolescents with regard to adjustment reaction. Can you think of any other that might make the diagnosis different between children and adolescents?

A Well, the primary reason for the difference in the labeling is simply the developmental stage of the child. It has to do with the developmental capabilities of the child and what kind of social interaction he's apt to be engaged in. No gross depression in younger children. People somehow interpret depression in the younger child.

They say this withdrawn behavior we say is because of an inner depression. But, this is not because the child says, "I'm blue; I'm down in the dumps," or that the child cries or does the kinds of things that we would say, "that's depression." So, some people say of a quiet withdrawn child that he has an inner depression.

Q Does the diagnostic label of adjustment reaction in and of itself say anything about the severity of the symptoms?

A No, unless that's qualified.

Q What about hyperkinetic reaction of the child, what symptoms?

A This is a somewhat confused term, because the notion of hyperactivity associated with minimal brain damage [24] which was developed relatively recently comes into the picture. But, hyperkinetic simply means overactive. Anything in which there is a degree of motor activity that is considerably greater than normal could be classified as a hyperkinetic reaction. There's nothing in that diagnostic counterclaim that says there has to be brain damage in that particular pattern.

Q It's a description of symptoms?

A Yes.

Q Of behavior?

A Yes.

Q There is a classification of personality disorders. Do these usually appear in children and adolescents?

A I think the term is considerably less used since TSM2 came out in 1968 or something; revision of the diagnostic statistical manual introduced a much more

extensive way of looking at adjustment reactions. The difference in the ideas behind these is that a personality disorder is seen as one in which a pattern of functioning has become quite fixed within the person's makeup and as a persistent way of that person's interacting with other people. It's likely to go on over years. It's a part of the makeup.

I think this is not very commonly used now in children. It is used to some extent in adolescents and probably a more applicable term for adults when personality qualities [25] are more fixed and do tend to persist longer.

And people have used the adjustment reaction of childhood as a much more relevant way of looking at what you see in a child who seems to be changing anyway with this developmental progress.

Q But, at the time that label is fixed is that basically a statement that from everything known those symptoms are not fixed and probably will go away eventually?

A The personality disorders?

Q Adjustment reaction.

A That's a prediction that's made looking at the total picture. Whereas, diagnosis of personality disorder would be because the history indicates that this has been persistent through a variety of circumstances over a period of time and it looks as though it's likely to keep on characterizing a personal functioning.

Q So, you might first give a diagnosis of adjustment reaction of childhood or adolescence and then later, if the same pattern persisted, change that to a personality disorder.

A Correct.

Q As it became fixed.

A Right, that would be probably a quite appropriate change of diagnosis. The tendency that is present in the field to try to make the least pejorative diagnosis at the first instance. I think this has not been true of the [26] field forever when people were looking for more rigorous ways to classify things and trying to get them in categories much harder, working at it much harder than we are now as a way of trying to understand what we're dealing with. They perhaps did tend more to say, "Uh-huh, I see a little bit of a sign here that says it ought to be classified as schizophrenic." Whereas, the tendency more recently has been in the direction of trying to put the least pejorative, severe label on things. So, people will tend to say adjustment reaction to child and adolescents and only in the light of early experience. You say, "well, that was a bad estimate at that time; or something else has gone on; and now we have to change it to a more persistent, serious kind of labeling."

Q So, would you categorize the adjustment reaction diagnosis as being a conservative one?

A Yes.

Q Can you think of any other major categories of mental illness of children and adolescents which need to be described?

Q We haven't talked at all about neurosis. This is another concept which generally refers to a less serious condition than a psychosis, which refers to a condition that is seen as probably being more transient than a personality disorder, on the average more transient, which is thought of as being more of an intrapsychic distortion, say, than the [27] typical adjustment reaction.

Adjustment reaction tends to be more in a variant social behavior that's fairly extreme. But, the neurosis may be such a thing as a conversion reaction, a hysterical neurosis in which—well, an extreme case say blindness. A person acts and believes himself to be blind. They deny any ability to see things in front of them. As far as we can make out, they're not lying. They're not faking it, although if you get them up and lead them across the room, they will somehow or another manage to sidestep an obstacle on the way. But, as far as their consciousness is concerned, they're not seeing.

There are a variety of other neurotic reactions.

Q Would these become a diagnoses for children or adolescents?

A Hysterical conversion reaction is probably a fairly common circumstance of early teenage youngsters. It's an interesting thing it was a common diagnosis 75 years to a hundred years ago. When I came to North Carolina for my psychiatric training, it was at a time when most of the leading working psychiatry in this country had been done in the Northeast, northcentral states, the West; and there hadn't been a great deal in the South. And, people were saying hysteria used to happen back in Freud's day; but it doesn't any more. It's a very rare condition.
[28]

A study was done in North Carolina that showed something like 13% of the teenage kids coming through the out-patient mental health program there in the psychiatry department had behavior and functioning that was appropriately diagnoised as hysterical. It seems to be associated with more fundamentalistic religious views, less advanced modern social circumstances. You find it in rural populations where there's a high level of fundamentalist belief and so on.

Q You mentioned blindness is one type of hysterical reaction. Are there other common ones?

A The term is used to apply to situations in which there is change in the person's perceived sensory function or their voluntary motor activities, that is, as far as one can make out, due to psychological factors, not to any somatic changes. So, it can involve pseudoconvulsions of motor activity. It can involve paralysis or lack of motor activity, a paralyzed limb. It can involve unusual or strange sensory experience such as perception of and reporting of pain or anesthesia, inability to feel anything with the hand, say. It can mimic many neurological conditions. But, when the evaluation is done, no neurological evidence is found. For instance, neurological damage can result in anesthesia of a part of the hand; but there's almost no neurological condition—there is no neurological condition that can result [29] up to this point (indicating) and going no further. There are persons who say that I can't feel anything from here down. And, you can stick them with pins; and they don't jump. Yet, there's no way neurologically that it can happen on that basis. So, that covers that range of conditions.

Q You think that pretty much covers, say, 90% of the diagnoses?

A The psychosis, neurosis, personality disorders and adjustment reactions. We could get into some psychosomatic disorders, childhood dermatitis, a variety of psychosomatic disorders in which there is pathological change in the body tissue and so on, which appear to be to a significant extent due to psychological reactions in the person's life.

Q Would these be admitting diagnoses to the regional hospital in the psychomatic illnesses?

A I am not aware of that being admitting diagnosis to the regional hospital. That would be more often seen in a pediatric hospital. The pediatrician might call in psychiatric help. It wouldn't be one of the things for admission. It very rarely crops up. I'm not aware of any case that has been admitted since I've been here.

Q Doctor Messinger who testified in this case characterized adjustment reaction of childhood and adolescence and hyperkinetic reaction as being rather benign and common diagnoses. In your opinion, would the fact they're common [30] diagnoses affect need for hospitalization in individual cases?

A No, depending on the total judgment of the circumstances and the sort of condition are grounds for hospitalization. There's no reason why it shouldn't be appropriate for hospitalization; some of the time the diagnosis is not that important in the hospital decision. It's the judgment of the total circumstances.

Q Well, how important is it that two psychiatrists might put a different diagnostic label on the same symptoms?

A Well, I don't think it should be too important. Certainly, we ought to be trying to standardize diagnoses, so we can arrive at better judgments, where we can be more consistent. That will be the millenium when we can do that, when we know what these things are all about so well that we can put a clear common label that has meaning in terms of what we do and so on.

Unfortunately, I think we've been overfocused on the medical model as the only consideration. That is we have looked for conditions that were analogous—But, it's increasingly apparent that the conditions we're talking

about are ones that have multiple factors involved and complex reaction patterns to a total somatic, social, psychological context. And, we probably haven't gone far enough in adding diagnoses of family or action patterns or other things to our categories, [31] ways of characterizing as we see them. If the family interaction pattern is really side-tracked, and the overt manifestations are relatively mild in the child, that can be a very serious circumstance, although the label itself looks very benign.

Q For example—

A I think almost anybody in the field today is really looking at things as much as they can in that kind of a way. We have to go back to using labels that have a long history of evolution and derived at a certain point. The Joint Commission Standards on Accreditation of hospitals —we have to have diagnostic labels, and those diagnostic labels have come about from a medical framework, a medical perspective and assume a certain form that's obligatory to meet certain standards and that has a certain utility.

Q But—

A It isn't the whole picture, and we need to go very much beyond that. So, you're going to get variations in diagnoses. Probably if you ask many psychiatrists who are using different labels what they're going to do about a thing, what they think would be the appropriate action, you'll find that many cases there'll be much more agreement than in labelling of children. They'll say, "Yes, this child belongs in the hospital," although they might be using different labels to say so.

[32]

Q Well, then how would the child be treated once

he was in the hospital? What difference would the label make with respect to treatment?

A Certainly, in cases where the dianosis is quite clear and where many people would agree on it, the label would make some difference in diagnosis. Even in more uncertain cases the labeling may suggest some direction in trying treatment. There are certain drugs that are by experience considerably more effective for people who are psychotic, the major tranquilizers. The minor tranquilizers would be more appropriate to use in cases of anxiety, hyperactivity and so on. If the hyperactivity is specifically the kind that is associated with minimal brain damage, there are other things. So, the diagnosis can make some difference In terms of a general psychological or social minute treatment of a child, there probably is ostensibly less difference.

An environment that is concerned about disorders of behavior, that is interested in feelings, that encourages constructive interaction with your peers or with the authority figures around you is probably more generally applicable to almost anything we see. We may make some differences depending on individual circumstances. A severely inhibited child, we'll try to more actively bring out in the open; and a hyperactive or hyperaggessive child, we might try to draw out certain things while controlling others. Try to teach [33] the child the difference between total expression and expression of certain portions. So, we do make some differences. Again, not so much related to the diagnosis in the management of the child as related to his particular circumstances, particular areas in which he appears to be having problems in interaction with other people and so forth.

Q Would the diagnostic lavel of adjustment reaction, which can cover a number of behaviors and symptoms, what kind of treatment would be indicated?

A There's a range of treatments that might be considered appropriate under various circumstances. It would depend partly on—Well, say a private facility that could limit the number of patients it took and provide a long term treatment, they might take a child like that and over a period of a number of weeks or even a number of months involve the child in individual play therapy to express as much of what was behind his behavior problem and try to resolve it with that sort of approach. Where we have to—Well, another program might also be functioning on a private basis with as much resources as they needed to do it and be using a behavioral modification approach where they would try to as clearly as possible identify where the child's behavior is going wrong and then foster alternative behaviors, positive reinforcement alternative behaviors. This probably is on the average a more rapid kind of treatment. And, empirically, [34] I don't know of any evidence there's any as good. There are certain theoretical positions from which people say that's bad and this is good. But, it seems to work. And, I don't know if we know enough about the total progress of a person's life to really say—

Q One child that's diagnosed with adjustment reaction might be aggressive, and another child might be withdrawn.

A Uh-huh (affirmative).

Q And, their treatments would be based on a particular behavior that they're showing.

A Uh-huh (affirmative).

Q Disregarding diagnostic—

A What's needed to get them back to a more functional way of behavior.

Q In treating children and adolescents what difference

does it make to treatment that the child initially does not want to be treated, does not want to come to a psychiatrist, or does not want to come to the hospital?

A My experience, it's very rare for a child to ever want to be treated to begin with. Children in our society and probably in most are very used to being pushed around a good deal by their parents. They are taken to school because the parents say, "you're going to school;" which may in some instance be because the law says, "If you don't take your kids to school, we'll do something to you." But, there is a [35] whole set of things in leading to why a child goes to school and what's expected of a child in school. Children, depending on their age and families, go on vacation with no decision in the process. They are treked around where the parents want them to go. When children are brought for treatment, it's part of this whole context.

I've found children who after some several visits begin to find it's kind of fun to go see the shrink. He's kind of a neat guy; and, you know, they enjoy coming. But, it's very rare to find a 7 or 8 or 9 year old child who even after quite a long time and quite positive relationships could say why he is coming and be electing to come to deal with his symptoms, to deal with his disorder.

Q What about an adolescent, say, a 14 or 15 year old?

A By around 12 or 13, 14 certainly, you find that some kids who can make the election, who can in a positive sort of way say, "I have something wrong with me; I want somebody to help me with it." I'd say it would be very rare before 12, becoming of some significance beyond 12.

Q What about treatment of adolescents who are saying that they don't want to come?

A If I'm treating a youngster of that age, I would very much like to fairly quickly arrive at the point where he says, "Okay, you know, I'm with it;" and treatment will progress better. But, I have to go by my best judgment of [36] the situation as to how disordered the child's functioning is. And, if my clinical judgment is that it's a serious disorder, that it's going to be significantly impairing of the child or if the manifest disorder is relatively mild but the interaction in the family is of the sort that's likely to perpetuate or aggravate and develop into something more serious, then I would go along with the parents' wish to have the child treated, whether the child wants it or not. And, that would be my job to work through that resistance as well as I could and get the child involved in positive progressive treatment processes.

Q In your training in child psychiatry were you trained to get through their resistance?

A Yes, this is a normal part of the approach in training. This is something that you have to do.

Q What about other mental health professionals, other than psychiatrists, would they also have received training in how to get through the resistance of children and adolescents?

A A huge discussion of literature, much involvement in training and so on is how you work with this type of patient.

I remember one person in a training session when I was presenting a case I was working with, specifically, the question, "Do you ever expect to have any sickness insight on [37] the part of this patient; do you expect this patient to know that 'I am sick' and to receive treat-

ment?" It was a very severely disturbed young child. There's no way that—That was a childhood schizophrenic.

Q Are you familiar with an article by Rosenhan called "On Being Sane in Insane Places?"

A Yes, it appeared—

Q Could you just describe briefly what that study was.

A This a study which is minimally reported in Science in terms of the detail of how the detail of how the study was carried out in which 8 people who functioned as voluntary subjects in the experiment made appearances at hospitals. They requested a chance to come in for evaluation. They went for the evaluations. It doesn't report the details in terms of—he says 8 people went to 12 hospitals. Some of the people must have gone at least twice. I don't know how many of them. Whether one of them went 5 times and all the others went 1 time or what. They appeared at the, I suppose, the admissions office of the hospital. He didn't specify whether it was the out-patient clinic or the hospital or whether it was the admissions office or what. And, they said, "I am hearing voices." When asked, they said the voices said, "Thud, empty—" There was another word. And, at some point in what went on, they don't indicate in the report [38] how long the interviews were or anything else; but at some point hospitalization was recommended. And, the people who volunteered accepted hospitalization; and they were admitted to the hospital for a period of time.

Q Do you have any opinion with regard to the methodology used in that study?

A It's a pretty limited methodology, because it tried one thing and based the findings on what happened. Now, there is no comparison of what would happen if alternatives had been attempted. The report, as I say, is a very limited report and very little detail given. They report certain things that were done and certain consequences that followed but almost nothing about all of the surround that must have been there. I can't conceive anybody going up to hospital admissions office and saying, "I hear a voice and thud;" and somebody saying, "Gee, you'd better get in the hospital." It must have been a much more extensive process.

Q Well, in your experience would you have expected a sane person to come to the hospital reporting such symptoms with the purpose of getting into the hospital?

A No, I wouldn't expect a sane person, no. Well, that gets into what you mean by sane. Sane is a legal term really, not a psychiatric term.

Q Well, in psychiatry—a psychiatrist's experience, do they expect a healthy person to walk up and to report [39] symptoms of a serious mental illness and to be distrustful of what is reported to them?

A There is a level of concern in the profession about that sort of thing, that is addressed to that kind of thing in training and so on. The whole issue of malingering, and which perhaps has been most acutely focused on in wartime situations of that sort where somebody might be malingering to get out of a very high hazard situation—Most people in the field have come to view that malingering is probably far less common than was earlier thought or even the average layman would be inclined to say.

Some of the things that we deal with, say the hysteria that we were speaking of before, there are still, I'm sure, many layman who would say that person is just faking. We are as a profession quite concerned about the

issue of malingering in insurance situations. There is psychological malingering as well as things like low back pain and other things that members of the medical profession see. So, there is concern about the issue of malingering. And, I would suppose that if somebody came along with some kind of odd symptoms that some place down the line they would begin to wonder, "Hey, is this person in an insurance situation or some other kind of situation where he's faking for a certain advantage?" But, that would be the framework from which I would think of somebody faking something.

[40]

Q If a patient, prospective patient presented himself to you with signs of a psychosis, what action might you take at that time?

A I would think if I were in a hospital context, if that were available to me, I might offer it as a possible alternative. I might at the same time suggest another possibility, suggest trying to work this out without leaving the home, community, job, whatever; try to work it out on an out-patient basis with the hospital as a reserved alternative that could be available at a later time.

Q But, you might offer some kind of treatment and then worry about malingering later on?

A Uh-huh (affirmative), with an adult I would typically, unless there's a major social risk and so on involved, I would leave it up to the person. Tell him what the alternatives were and leave it up to him and see which one he wanted to do. Use it to try to get a handle on what's going on.

Q One of the contentions that's been made in this case is that parents sometimes attempt to scapegoat

certain children in the family by labeling a particular child as mentally ill and everybody else in the family is healthy. In your experience is that a phenomenon that you've seen?

A I'll qualify the way you worded it by saying or taking out the words, "parents try to." Parents certainly do. Any social group, there's some risk of this happening. [41] When a group can't work out certain problems within the group, a group consensus develops that it's all so and so's fault. And, some hopefully wiser more objective outside observer might be able to say that's an inappropriate judgment on their part. And, that person did such and such kind of thing to focus attention on him; but this person over here was in the meantime subverting the group's effort. So, everything would be turned around; and they identified that as what was going on and recognized that that person was also causing trouble. Three other people in the group were causing trouble. This kind of thing does go on in families.

The alcoholic may be making very significant efforts to deal with this; but because of his alcoholism, they scapegoat him and blame him with everything else.

Q Or, it might be an adult member of the family, the husband or the wife?

A Yes.

Q Or, someone else?

A Yes.

Q In your experience how often does this occur?

A That's very very hard to answer. I can't put a percentage figure on it. There is probably some minimum of it in every group that interacts very extensively. When it

becomes significant, when it becomes an important factor in what's going on, when it becomes fixed on one person, it's[42] probably fairly common in terms of families in general of patients we see in child psychiatry; more common probably than in the average family. But, it is a part of what's going on.

Q Have you received training in how to determine the actual dynamics of the situation as by what the parents present to you?

A This is certainly a major part of psychiatric training, child psychiatric training is to try to do this. It can be exceedingly difficult. But, it's a part of what child psychiatric training is all about. It's how to look beyond what you're told, what's on the surface of the situation and try to see what's going on in subtler ways.

Q Would it be part of psychiatric training in general as opposed to child psychiatric training?

A Yes, again, this is a changing situation, because if you look back 25 years, psychiatric training was generally still considerably oriented toward the problem with the individual. Twenty-five years ago there was a very clear difference between psycho-analytically based training programs where people were being trained to look intensively and dynamically into family context and so on and non-analytically based programs which were looking much more for disease condition in the individuals. I think the dynamic perspective has spread to become essentially part of the ground work for [43] everybody in the field. And, people are going considerably beyond the psycho-dynamic/psycho-analytic perspective on dynamics and become much more aware of other social dynamics.

Q Would this—

A This is pretty much a normal part of training that everybody is taught to look at things in terms of the complex system of dynamics in which people function.

Q Would this also be true of other mental health professionals, psychologists, psychiatric social workers and nurses?

A Yes, it's sort of a standard part of the perspective.

Q How, say, in an interview situation or in a series of interviews do you deal with these problems, the problem of scapegoating, determining true family dynamics? What techniques in interviewing do you use?

A I hardly know how to put it in terms of technique. Theodor Reik who entitled one of his books Listening With a Third Ear, this is trying to be an independent observer of what goes on, trying to look at the totality of the context and see things that other people are overlooking, human communications. There is a good emphasis on paying attention to the words people say. But, there are many other indicators of what's going on in a situation.

If I'm seeing a family in a family group, then I have a chance to see not only what the mother is saying, but [44] the tricky little points at which father interrupts; and his choice of repetitive circumstances of the same context in which he interrupts may clue me to a significant dynamics of what's going on.

Seeing a patient individually—I recall one woman I was seeing one time. Just all kinds of explorations and inquiry led to no indication of any fluctuation of feelings about the things she was talking about. Everything was just sort of flat, this was it. I noticed, as I was talking, that

at times her leg muscles contracted in a way that the toe of the foot that was crossed over the other leg was pointed severely down; and at other times it was hanging relaxed. I drew this to her attention. She had been completely unaware of this as a thing that was going on. She couldn't explain.

Finally, I said, "Well, look, I'm going to guess that that's an indicator of tension and anxiety." And, I began to say every time I saw that toe go down, "What are you tense and anxious about?" And, gradually she began to be able to identify in herself other indicators of tension and anxiety. And, we began to be able to get them out. And, what you're trying to do is to look for just those sorts of subtle behavioral cues in a person in his own processes or in interaction with a group. To be able to identify things that are under current to what people are saying and what's [45] on the surface.

Q Have you visited all of the children and adolescent programs in the regional hospitals?

A Yes.

Q Have you visited the Children's Building at Central State Hospital?

A Yes.

Q In your opinion is the physical plant of the physical building at Central State similar to the physical plant at the other regional hospitals?

A It's quite similar to most of them. At this point the exception is Southwestern Regional Hospital which is using an old army hospital facility, and the physical layout is quite different. The quality of construction is very

different. It's quite a different plant. All the others are very much similar, modern cottage for 24 or 40 or so many patients; but with separate areas that can be divided up for different groups of children and adolescents and so on.

Q At Southwestern is there a separate children and adolescents building?

A There is a separate unit, separate building for children. At present they're operating a day program for adolescents who are housed in the general wards. It's a pattern they're using in the Atlanta Region and have not arrived at the point of having a separate building for adolescents.

[46]

Q Are you familiar with the treatment programs at the various hospitals for children and adolescents?

A To some degree. I've had a chance to participate in the staff meetings and interact with the staff at each of the hospitals and to get some sense of the treatment programs.

Q Are they fairly similar?

A There is some variability; some heavier use of behavior modification approach in some than in others. GMHI with the history of the association, with Emory and the psycho-analytic perspective, they've had a history of more of a long term expressive therapy. They all, I'm sure, are using some behavior modification. They all have quite well developed activity programs for children while they're in the hospital.

Q What about school?

A They all have school facilities and provide educa-

tional activities for the children while they're in the hospital.

Q Do the schools use specially trained teachers?

A Yes.

Q Are they hospital employees, or do you know?

A This varies. In some cases they are. Title I or Title V of the Education Act provides teachers who can be assigned from the education system to the hospital. When that's the case, they're paid 9 months a year from education [47] funds. But, because the hospital is a 12 months a year activity and the educational component is important year round, they're paid by mental health for the other three months. In some cases they are directly hospital employees.

Q Are you aware of any particular problems with parents not taking their children home when the staff of the hospital recommends discharge?

A I think this is probably a very occasional problem. This is most often the case with really quite seriously disturbed children. With a child who's schizophrenic, the parents may have a great deal of concern and apprehension about caring for the child as a memory of what happened earlier and so on. And, the hospital feels that it really would be in the child's best interest to be at home and to continue whatever is going on in a family and community context. The parents may still be unwilling to do that. But, other than extreme cases I'm certainly not aware of that being a problem. The natural parents would be willing to come and get the child at the time the hospital says it's appropriate. Parents are pretty used to doing what doctors tell them.

Q You've recently been working on developing a list of children who might need to be placed in specialized foster homes.

A Uh-huh (affirmative)

[48]

Q Would you explain please how that list was devised and what the reason for it was.

A Well, this is a concern that I had been aware of since I came to this position. There were some children around who hospitals were having great difficulties finding proper placement for. Hospitals have been largely dependent on Department of Family and Children's Services for making such arrangements. The legal conditions around providing child care facilities and so on are organized in that way. And, the hospitals have sometimes been quite frustrated in trying to work out an arrangement, feeling that they could do it themselves. But, they don't have the legal authority and so on.

With the many problems that have existed in the development of child and adolescent services, it's one I haven't put a great deal of effort into myself until recently. Now, over this past summer I have been involved in some activity that we're pointing in this direction. And, the Department of Social Services began to express some concerns this fall joined in with the other things that were going on.

We recently had an interdivisional committee that's prepared a series of recommendations including a significant expansion of these specialized foster care capabilities of the state to submit to Mr. Parham. In this context of this all this going on, the issues around this case brought

it [49] again to quite acute attention. And, the combination of these motivations, we put together a list. We asked each of the hospitals to report to us on the kids they had for whom they felt such a resource might be appropriate.

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Q One of the essential contentions in this case is that there's a necessity of judicial or administrative hearing including a right to counsel and independent psychiatric exam, confrontation and cross examination of witnesses prior to the decision to hospitalize a child. In your opinion is there a necessity in each case for a judicial or administrative hearing with those attributes?

A I would think in many cases it would be quite disruptive. The child is already going through difficulty with his problem that he started with, and these are not good. If he needs to go in the hospital, that's certainly a change [55] from his normal life circumstances. That's true if he has to go into a hospital for tonsilitis or a mental hospital. It's another kind of thing and certainly has significant differences than a few days' stay in a general hospital for a medical condition. But, going to the hospital because you have something wrong with you is not that strange. Most kids as they grow up know and have found out that you go to a hospital because you have something wrong with you and consult with the doctor; and that seems to be the best thing to do. It's not that strange, I would say.

Due process proceedings in the court, witnesses and so on are much more alien in a child's life and airs all the dirty linen, not all of it probably, but it airs a significant amount of dirty linen in the child's life and parents' lives. And, all sorts of people sitting around passing judgment

on what's going on. And, it would be considerably more alien to the child's life than the somewhat familiar from the medical participation in dealing with problems.

Q If it became necessary for parents to apply to a court or to a hearing officer prior to the admission of children to the hospital and following the recommendation by the community program that the child needed hospitalization, do you believe that a number of parents would simply fail to file such a petition or request for hospitalization?

A I would think so, yes. There might be quite a number [56] of parents who would not want to get into that sort of a situation, but who would be able to work quite effectively with a hospitalization and return after a period of treatment and so on.

Q That's all the questions I have. Want a few minutes?

[Break]

CROSS EXAMINATION

BY MS. LINDBLOOM:

Q You mentioned before in your direct testimony that the community treatment centers, the community programs would determine whether hospitalization was appropriate and would make those recommendations to a regional hospital. Are there any written regulations or policies that you're aware of that speak to that or describe that?

A I believe so. They're not policies that say that that's absolute. Policies that say that's the preferred way of functioning. I don't think we would ever have policies that would say that's absolute. If it was clear that hospitalization was the need in the clinical judgment of

responsible physicians, then hospitalization would occur at that time. The procedure at that time would be to inform the community center that the hospitalization occurred to involve the community center with the parents or with the planning for the eventual disposition and so on.

Q Assuming—

[57]

A But, the admission might have occurred at the hospital without having gone through the community center.

Q Given that that situation might exist, is there any written guidelines, policies or regulations that speak to that, in other words, that you're aware of?

A I'm not certainly aware of any that do speak to that. I'd have to review hospital policies. I'd have to review division policy statements to check and see if that is specifically included.

Q You spoke of two general criteria that are used when hospitalization was appropriate. One was acute, severe degree of behavior. The second was social circumstances. Okay, assuming emergency situations, emergency admission would be appropriate, are there any other situations where acute—Can you think of any other situation where you mentioned an acute, severe behavior problem? In other words, can you think of anything else; did you mean anything else by that, anything that wouldn't be covered by an emergency admission?

A I made the distinction between emergency which would usually be within 24 hours or less for getting somebody into the hospital and severe behavior disturbance where an attempt might be made to manage it in some

alternative way. Then the decision is made to get them in. Where that stops being an emergency and becomes a social circumstance judgment, [58] it's a mixture of both probably, most of the time.

Q Okay, specifically when you talked about the social circumstances, your second criterion, you spoke about breaking of the vicious cycle that you described, that you described.

A Yes.

Q Again, in a non-emergency situation would there be any other alternatives to hospitalization in that instance? In other words, to break this cycle you spoke of.

A There could be, yes. You might try a foster placement.

Q Okay.

A I think probably in the present situation the hospital is a more expedient and quicker way to get the cycle broken and the child back into the home than going through the crisis of negotiating a foster place. There are some situations where there are emergency foster facilities where a child can be placed for a fairly brief time, overnight or up to a couple of weeks. And, this might be appropriately used at times. That would have to be, again, a clinical judgment as to whether just moving the child out of the existing situation with a relatively low level of other intervention, treatment and so on would be sufficient or whether you want to couple it with a fairly intensive treatment program.

[59]

Q How many of these emergency foster facilities you spoke of are available within the state?

A I don't offhand know. Clayton has quite well

developed emergency foster capabilities. There are some in other places. I don't know the details.

Q When you speak of the foster facilities, are those facilities that the local DFCS, the county DFCS office would have knowledge of and have recruited one as opposed to one specifically recruited by the Division of Mental Health, let's say?

A The ones I know most about are the ones in Clayton County—are described there as a protective services commission, police, court workers, social services, mental health; organizationally it's under DFCS.

Q You mentioned a training conference coming up in January.

A Uh-huh (affirmative).

Q Concerning the rights of children. Are there again any written policies or regulations now on the rights of children in terms of admissions or treatment in the state mental health facilities at present?

A No.

Q Okay.

A Except as they're included in hospital policy statements and so on.

[60]

Q Are there presently children hospitalized right now in the 8 regional hospitals in the state who hospital personnel in those specific hospitals indicate do not need to be institutionalized?

A Yes.

Q How many?

A We mentioned the 14 or 15 whom the hospital has judged to be in need of specialized foster placement. I

don't offhand know the number. It might be something approaching that number whom the hospital has judged needs residential treatment programs over a much longer period of time.

Q Do you regularly request that information about children in that position from the hospitals on a regular basis, systematic basis?

A We have not regularly requested it, because we have no capability of affecting the situation. I'm sure when we do have that capability, it will be a regular requested item of information from all of the hospitals.

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[68]

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Q Okay, again, going back to when you talked about adjustment reactions, you talked about it in terms of behavior, social behavior. Because of that, because of its being social behavior, would not the placing of the label of adjustment reaction be dependent on the mind of the labeler. In other words, whether the person who's placing the label, is going to place the label deems the behavior to be socially unacceptable or not.

A It certainly would have to be true, yes, that the person would agree that the intensity, the level, the extent of his behavior was socially unacceptable. What social unacceptability means; it means that the social group is not accepting; and that's why they brought them there in the first place.

Q Again, you were referring to, in discussing the importance of the diagnosis itself and correspondingly the treatment in terms of drugs that would be given, if there was a misdiagnosis and a wrong drug was given—Let's say an inappropriate drug was given on the basis of a

misdiagnosis, would there be an adverse effect on the patient?

A At the present state of the art most of the medications we use have a high level of—There is a high level of tolerance to these. The specific medication, the dosage and so on [69] is almost known by trial. Now, that's not entirely true. As I said before, a diagnosis of psychosis would make certain drugs the ones you try first. But, in specific cases a particular drug may have little or no beneficial effect. And, you're only going to know that by trying it.

We're not in the situations we are with anti-biotics where they can take a culture of the organism and test the drugs on a culture plate and see which one is most effective. The only way we have to test is to test in the person himself.

Q But, you can get an adverse reaction from using a drug that's inappropriate based on a misdiagnosis?

A No, I wouldn't buy that statement.

Q Okay, I just want to clarify what you were saying.

A There are adverse effects of such drugs. You run a risk any time you try a drug that has capabilities of producing significant effects. It may have adverse effects. For a person for whom it has beneficial effects, you're balancing out the adverse against the beneficial.

Q Are there any statewide policies or regulations, again basically within the Division of Mental Health, of which you are aware that speak to the separation of adolescents from adults in the 8 regional hospitals?

A There are no—

Q Are there any being developed at the present time?

A Not as policies. We're programmatically working in [70] that direction to achieve that.

Q Okay.

A We've only recently in the Atlanta Region been able to work things out so the staff—staffing and so on made it possible to provide 7 hours a day in which the adolescents are in an adolescent group with staff especially focused to work with adolescent problems. And, they return to the adult units for the remainder of the hours.

Q Then, you're familiar, I would assume based on your last statement, with the practice at Atlanta Regional that 12 year olds are considered adults; and they would be placed on adult wards?

A I don't think it's 12. I think the 12's are included in the children's group, if I'm correct. If I'm remembering right, it's not till 13 that they're moved.

Q Okay. Would you agree, in other words—

A Incidentally, I have stressed in my conduct with all the regional hospitals that I feel they should use these kinds of age limits flexibly and in functional terms. And, a 13 or 14 year old who is still very childish in many ways ought to be selected to be managed in the children's unit. And, only those who are in a more mature level of functioning should be treated as adolescents. That would be true if they had an adolescents' unit and children's unit.

Q Okay, are you familiar with the policy at Central [71] State Hospital where if the patient is under the age of 17 and if they are pregnant or have a child, they can be sent and placed in an adult ward? Are you familiar with that?

A I'm not familiar with this as a policy, no.

Q If you were developing regulations as to—You know, you said you were going at that; that was a basic future goal or objective. Would you include such a policy as a general guideline?

A I would want a functional judgment to be made again.

Q Okay.

A If the having of a child involved the young woman in a much more adult perspective on her own life in the circumstances, then I think she ought to be processed as an adult. If she is a very young 17 year old, immature, who has had a child or who is pregnant and is very childish in her whole response to it, then I think she ought to stay in the adolescent unit.

Q Are all the physicians who work with children and adolescents at the 8 regional hospitals within the state—are all those physicians certified child psychiatrists?

A No.

Q Are they all certified general psychiatrists?

A No.

Q Are you aware in terms of numbers the number of those physicians that are certified child psychiatrists and [72A] also speak to the number that might be certified general psychiatrists.

A There are very few who are certified child psychiatrists any place in this state in terms of Board certified.

Q Right.

A There are, I think, only several who are trained in child psychiatry in several of the institutions. Some of the institutions have eligible trained certified child psychia-

trists who are available on a consulting basis part of the time. But, one of the physicians effectively involved in the Columbus Region is a pediatrician, not primarily trained in psychiatry but trained in pediatrics and with a number of years' experience in psychiatry, child psychiatry.

We're seriously limited in terms of having anything like as many child psychiatrists as we would like to see in the regional hospitals.

Q You say, when you were speaking about scapegoating before, that sometimes it was difficult to see through to be able to understand the family situation to see if this was actually taking place. Would that be compounded then—in other words—that difficulty, would that be compounded by an admitting physician who would have problems understanding and speaking the English language?

A I'm sure it would.

Q Okay, again, you spoke that normally—

[73A]

A That is also a problem say with a northerner who comes down here and does not understand southern idioms.

Q Okay.

A That's part of what we have to work with.

Q You spoke also before about the fact that usually the natural parents of the child who had been admitted would take the child back in your experience, when the question was posed to you. But, you say that sometimes is not the case. Would you then say that parents can act

against the best interest of the child; that some parents can act against the best interest of their child?

A Yes.

Q Okay, is it—Assuming the natural parents of a child who have voluntarily admitted that child to an institution will not take him back, is it harmful for that child to be continued to remain hospitalized? In other words, assuming then the hospital personnel have stated that they feel he's no longer in need of that hospitalization.

A I'm sure, you know, a long persisting continuation in the hospital has some deleterious effects, yes.

Q Does your experience change—The question was asked you about whether or not natural parents take the child back when the hospital indicates to them that the child is ready to leave the institution. Is the same true with children who are in the Department of Family And Children's Services' [72B] custody?

A My impression is that the problem is considerably greater in that case. Natural parents, they have for the life of the child generally taken the position that that child is part of their family and they must deal with it. Foster parents would be more likely would be inclined to extend themselves to a degree for this foster child. But, they set a shorter limit on how far they go. There are some exceptions. There are some foster parents who are fantastic. But, I'd say on the average the child in DFCS's custody or foster placement who has these sorts of problems is more likely to be ejected from the family. Dumped on the mental system; dumped on the Human Resources System.

Q What would happen—Let's take a situation such as that. Let's say a local Department of Family and

Children's Services has voluntarily admitted a child; the hospital personnel involved with that child all conclude that he should be released from the hospital. What happens there? What procedures would happen? What would happen? Let's assume the hospital personnel have concluded that. What would happen?

A The basic step is the hospital personnel would contact the DFCS and say it's time for the child to leave the hospital. Get busy with it.

Q What if the Department of Family and Children's [73B] Services were unable to take the child right now?

A Then, it may be that there are further contacts, further efforts made; but the child stays in the hospital technically.

Q What efforts aside from what efforts the Department of Family and Children's Services might make after this point, after they've been notified—what further efforts would the hospital and/or the Division of Mental Health make for that child, if any?

A There have been efforts on the part of some of the regional hospitals staff to negotiate the DFCS so the hospital staff could seek out and recruit foster parents who would take these children and use the DFCS for the approvals and clearances. And, offers by the hospital staffs to provide continuing support, training supervision to these parents when they get the child. So far these efforts haven't been very successful. They have succeeded in some instances in getting some outside life for the child. I don't know of any that have created a lasting foster home as yet.

Q If I—

A The problem here in part is the history and tradition

of mental hospitals which have been dumping grounds in the past. As we try to move out of this, there are a lot of people who still treat them as dumping grounds. There are juvenile court judges who say, "I want this kid to be kept [74] in a hospital from here on out until he's grown." The DFCS takes the child to the hospital and says, "Now, it's off our hands." They're besieged with oversized case loads and so on to try and do things; and to take on the tough problem of a kid who's been through a period of hospitalization and is still not normal, back to regular who needs community living to get there, it's going to take some extra work. And, to take it on at a time when they're already carrying 70 or 80 normal foster cases is a huge requirement on them.

The community mental health programs have only been gradually been coming to the position of saying that the patient who is still in the hospital is still our patient. With a notion of the mental health center taking responsibility for all of the people in its catchman area and their mental health needs and having an on-going responsibility no matter where that person is, is a pretty new idea. And, they're only just gradually becoming involved in this.

A year and a half ago when I was here on a pre-employment visit, I heard a delightful story at Atlanta Regional. They said they've got one social worker out in the community program who keeps bugging them, saying, "When are you going to give me back my patient?" And, their reaction was, "Beaufiful, we've got one who's doing it. Now, let's keep it going. Let's get them all doing that."

Q But—

[75]

A This is only gradually happening in the total social process.

Q Specifically, going back to the hypothetical that I gave you.

A Uh-huh.

Q Assuming DFCS was the admitting person for the child and DFCS won't take the child back for one reason or another, assuming I'm the social worker in the hospital and the child is on my caseload, are there any regulations or policies that when I'm confronted with this situation would tell me what—specifically, what actions I might take, who else I might contact?

A I don't know of any policies or regulations. Atlanta Regional Children's Unit has worked out a practice where when a child of that sort is admitted, they enter into an agreement with the DFCS as to what their responsibilities are and what DFCS's continuing responsibilities are; and before the fact when the child comes to the hospital to set up the mechanism for getting the child out.

Q Those are policies?

A This is practice.

Q Practice at which hospital?

A Atlanta Regional I know specifically.

Q How about the other hospitals? Has this practice been adopted in other hospitals, the other 8 regional hospitals?

[76]

A I can't say that it is adopted with certainty. I don't know that kind of detail.

Q Okay.

A I believe this is operating at Augusta Regional in the children and adolescent program or something analogous to it. I'm not sure about all the others.

Q You mentioned—

A Another approach that is commonly used is for the hospital to contact the local mental health center and have them work with the DFCS to try to negotiate and work out a foster placement.

Q Is that written down, again? If I were a social worker, would I find that written down anywhere that that's a contact that I should make?

A I doubt it.

Q Okay.

A It may be, but I doubt it.

Q You spoke of a priority list that was developed this fall in terms of priority for specialized foster home placement.

A Un-huh.

Q When exactly, specifically, was that list—Can you give me in terms of a date or approximate date?

A A couple of weeks ago.

Q November?

[77]

A About two weeks ago.

Q November?

A Uh-huh (affirmative).

Q Okay. You mentioned also the two plaintiffs in this case, J.L. and J.R., were on that list. When were they placed on that list?

A At the time it was developed.

Q Again, two weeks ago?

A I requested this information from the hospital and put together the list. Both of those cases were on the list.

Q Okay. When you spoke of the 40 specialized foster homes, now are we speaking here about actual homes or are we talking about slot for homes?

A Slots.

Q Okay. How many actual specialized foster homes are within the state at present?

A I understand this is two children per home, 40 slots, 20 homes.

Q Okay.

A Probably with some of the kids you would place in those foster homes it would not be appropriate to put two children in.

Q Okay.

A So, we would probably have to operate at less than the 40 level, because we're limited to 20 homes.

[78]

Q Right.

A My understanding from the people in social services is that there are, I believe it's 15 or 16 homes currently operating and something in the neighborhood of 30 children placed in those homes. Those are approximate numbers.

Q In the letter of correspondence that you sent to the regional hospitals in order to form this priority list for specialized foster care, were they asked to indicate

the number of children—solely the number of children that needed specialized foster homes; or did they also indicate those children that were presently in their own hospitals that needed group homes? In other words, group homes as well as regular foster homes and the family care foster homes? Was that information given to you?

A Earlier I had requested information on children needed specialized services, continuing services. And, I had some general statistics.

Q Uh-huh.

A Across the state on how many the hospitals felt needed residential treatment care, how many needed specialized foster homes. Some of them mentioned cases they felt could fit into regular foster home where a group home was appropriate.

Q Right.

A But, it was more or less the figures I've given you, 14 or 15 specialized foster homes, about that number; and almost [79] that number for residential treatment, and a few odd cases that would perhaps be manageable in other resources.

Q Other types?

A Yes. We've had a reasonable capability of getting kids into group homes, institutional foster care, places such as St. Joseph's Methodist Children's Home and so on. They have been pressed, as I understand it, because they used to take, you know, fairly normal kids who, because of family circumstances, didn't have a place to live. They're being pushed more and more to take troubled kids. And, they're having a great deal of difficulty with it. They're doing the best they can. But, they are taking

them. And, we have some fairly good working relationships with mutual support, hospital personnel providing support and assistance to them in doing this. They're having to work with the school systems, because a lot of these kids need behavior disorder classrooms in the school. When they got to those homes, they have to go to public school. So, there's pressure on the school systems to provide enough behavior disorder classrooms in Decatur to take care of the children from Methodist Children's Home, for instance.

Q Uh-huh. You mentioned in terms of recruitment of foster homes, I think you were specifically addressing specialized foster homes, that the local county system of recruitment, in other words, where the case worker, the local DFCS county case [80] worker was actually doing the recruitment, I believe you said, was unsatisfactory.

A I believe—

Q Could you elaborate on that?

A Well, particularly in the smaller counties of which there are a lot of them in this state.

Q Yes.

A Very small DFCS staff, they have to do a little of everything. They're not able to specialize. A particular social worker may be carrying a case load of 70 or 80 foster placements that she is supposed to be supervising; managing disbursement of welfare relief funds of various; looking after handicapped adults and others; and whatever the responsibilities are across the whole range of services. And, on top of that whatever is done to recruit new foster homes, because there's an inevitable turnover on people who are willing to do this sort of thing. Some people are willing to do it for a period of time and reach

another stage in their life and say, "I can't do it any more." So, it's—Those people are stretched very thin. To get a need for a specialized foster home, it is going to take more effort and so on, more time. It's a big imposition. Most of them have been recruited from people who have been doing foster home work who have shown what they've done, the interest, the care, the capability to deal with a more serious problem; [81] and then they make a transition from being a regular foster home and providing a specialized foster home.

* * * * *

[95]

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Q Specifically—Let me ask you a specific question here. To your knowledge would a social worker who has like a child on her case load within the hospital, does she send, you know, regularly and on a systematic basis reports about that child to the DFCS office? Is that a written understanding? Is that an oral understanding that the hospital personnel will do that for a DFCS office that is concerned with that child's case?

A I don't think there's any written statement of this. I'm sure that 10 years or more ago it was standard practice that it was not done. The kid was there. That was it. They took care of him until they were ready to send him out, and then they tried to do something. Increasingly, the hospitals are actively soliciting on-going participation of DFCS personnel. When they have a child in the hospital, they are invited to come in for case reviews of their children. They're including them in the whole process as much as possible of evaluating how the child is progressing, when the circumstances [96] are going to be appropriate in trying to get, you know, the arrangements for placement established before the time comes for placement to occur. And, DFCS workers were regularly involved in case conferences.

Q Are you aware of, again, any obligation that's written down or any legal obligation that a local Department of Family and Children's Services county office would have to children who are patients in one of the 8 regional hospitals that are located within that county. In other words, is there any agreement, either written or oral understanding, that you're aware of for children who are patients there?

A I don't think the system is worked that way. I'm not sure quite what your question is. If a child comes from one county to the regional hospital, does the local DFCS have responsibility?

Q Right, I'm basically trying to find out if there's written down any kind of divisional guideline.

A I don't think there is any policy or intent that a county, say Baldwin County, would have responsibility with regard to all the children at Central Hospital. They would have responsibility only for Baldwin children.

Q Okay. Are you aware of any policy within the 8 regional hospitals to review particular child's, say juvenile's, child's or adolescent's case systematically? In other words, on a regular basis. I'm talking specifically now about his need— [97] to determine his need for hospitalization and alternative placement.

A Any of our hospitals that have standard hospital accreditation have requirements of that sort for the Commission on Accreditation of Hospitals. Any hospital aspiring to that will have to be in line with that when they do. We are actively encouraging, and as a divisional policy or a division code we have accreditation of hos-

pitals down as something to be achieved within the next few years.

Q Uh-huh.

A We actively encourage all the hospitals to have developed such policies. And, I believe all of them currently have some form of utilization review committee or some such procedure that's in their policy as on how all cases in the hospital will be checked at intervals after hospitalization.

Q But, this, in other words—

A The first interval being checking on the appropriateness of the hospitalization in the first place and its continuation. Then, at some fixed interval after that a recheck to be sure that the continuing hospitalization is still appropriate.

Q There would then be, in other words, there's a variation. In other words, each of the regional hospitals has their own way of dealing with that, their own way of dealing with review.

A Yes.

[98]

Q There's no, like, regulations statewide that they are required to follow in that respect?

A This is a place we haven't gotten to at the division level.

Q Okay.

A I'm sure it's a direction we're moving in.

Q Okay.

A We're trying to get things to that point where we

will have clear statewide policies. We're working through the process of getting there.

Q Okay. I'd like to turn now, going back to your direct testimony again, you talked about salaries and pay scales of professionals in private hospitals. Do you feel that the salaries that the state would offer let's say a psychiatrist or any mental health personnel to work in their facilities, that in comparison to what mental health personnel might get at a private facility might—

A Disincline them to take—

Q Thank you very much. That's just what I would have liked to have said.

A Yeah, I'm sure that if we could increase the pay scale, we could recruit more people to work within our system to some extent. This is like the situation of the academic psychiatrist who typically makes less than he could make on the outside. We are still relying, I think unduly, on a [99] person's dedication to a particular kind of job to get them there, rather than a salary scale. I'm making a hell of a lot less than I would be making in private practice and doing something that I consider much more exciting and am glad to be here. Wouldn't want to be in private practice. But, it would be nice to make something closer to what they're getting.

Q Okay. The next couple of questions I want to ask you, I want to make clear to you these questions are framed assuming these are non-emergency situations. We're not speaking here about a situation that would warrant emergency admission.

A Uh-huh (affirmative).

Q Do you believe that representation of a juvenile, or a child or an adolescent, at a pre-commitment, either

an administrative or judicial hearing, by having an attorney there who was speaking for his interests—again, in a non-emergency setting—would be harmful to his well-being or his interest?

A I'm not sure I understand the question.

Q Would you like for me to—

A I'm not sure how elaborate the process would be or if the juvenile is there, how long this takes, what goes on. If somebody went to the judge's chambers and said, "Hey, we got this kid out there that some of us think needs to be in the hospital;" and there was an attorney and the parents; and they discussed it, you know, that probably wouldn't [100] be harmful to the kid.

Q Okay, I think you'll understand more by my next few questions here.

A Okay.

Q You mentioned that in arriving at a decision, in other words, as a psychiatrist if a child or adolescent is in front of you and you're trying to make a decision on whether hospitalization is appropriate, you said in arriving at that decision you would want as complete and thorough a background information on that child as possible in order to make that decision. Is that a correct statement of what you said?

A I don't think so. It would be some situations where I could sit down with the parents and see the kid and in 20 minutes I could say, "I think hospitalization is going to be necessary. We'll get all that background information as we go along. We're going to need that in the total effort to help you and the child to work this thing out."

Q Uh-huh.

A But, it's obvious that hospitalization is needed now.

Q Given the fact that with certain people that you could not make a diagnosis fairly quickly, in general would it not be helpful as a general rule—would it not be helpful to get as complete and thorough a background as possible on the child?

[101]

A I agree with that.

Q Would not a hearing, an administrative hearing in which information would be brought out on both sides, information would be obtained from the school, let's say, as the child was in school as to his behavior?

A If it's a non-emergency situation we're—

Q Excuse me.

A If it's a non-emergency situation, we're going to ordinarily have time to get that. That's pretty routine to get that information.

Q Right. But, that would be information that you would want to have and that would be helpful?

A Yes.

Q Okay. If, again, when you mentioned the difficulty of being able to sit back and take a neutral view of seeing the dynamics of what exactly is happening within a family, above and beyond what is actually told to you by the parents or by the child, would—can you see a process such as a hearing being helpful in being able to collect more information that might be—that potentially would be important, that might be, let's say, embarrassing for the parents to admit. Now, specifically, I'm referring to, let's say, there was an incident of child abuse with the parents and the child. Would not it be helpful to have a hearing or a process similar to that in order that that information could come out?

[102]

A My only experience is that a great deal of information is going to come out through a long slow process and is only going to come out by establishing a relationship between the mental health professional and the child and parents and so on. It isn't going to come out in any hearing, no matter how many questions are thrown at people.

I've had many situations that I've dealt with myself with families where the really essential things for full understanding were things they couldn't conceptualize themselves at the beginning of the situation and couldn't have told you no matter how you cross examined them.

Q Let me clarify my question. I'm not envisioning—My previous question was based on the idea of at this hearing, be it administrative or judicial, that whoever was presiding would have access to information, let's say, concerning the report on child abuse or further information that would help in this situation as opposed to having legal counsel available who would grill the parent on the stand and this type of thing. Do you see what I mean?

A Supposing there was enough such information floating around where people could get at it—The kinds of things we have to deal with are so often things that aren't in that realm. I can't really imagine a more extensive information system, gathering system than we have now in dealing with families. We're using schools, using the family physician and [103] other resources, the family's reports and what not—which is going to be able to elicit information that can be presented within a couple of hours of hearing that's going to be of any significant help to me, except in very rare cases. Something might crop up that would go beyond what I would get in a normal evaluation process.

[104]

Q Would the admitting psychiatrists—again, speak to all of the 8 regional hospitals here—have the resources available, in other words, to track down this information? Let's talk about the school record of a child; speak about a teacher who might see him 8 hours a day—in other words, to supplement the information that they're getting from the parents.

A Of course, when you're talking about the hospital psychiatrist—

Q Right.

A You're probably talking about the emergency situation where the decision is not going to depend on getting all that information. That's going to come as a supplement. He could either get a release, write to the school for the information. He can contact the local mental health center, and this will help him much more. The local mental health center will go out and get that information and pass it on to the hospital even in an emergency admission case. If it's not an emergency admission and has been referred back from the hospital to the [104] community center or has come through the community center, they're in the position to get that information and do routinely.

Q Do admitting physicians in the hospitals have a series of written guidelines that dictate, again, set out information that should be gathered, in other words, before they make a decision; in other words, is this set out anywhere in a written policy? Again, assume I'm an admitting hospital psychologist, not an emergency; I appreciate your distinction for the emergency; but, in a non-emergency case that would dictate to me what actions I should take?

A I think probably I would assume all of the hospitals have some sort of standardized written-out statements as

to what goes into a basic work-up and so on. This is so much a part of one's professional education.

Q Sure.

A To know that what you do is to take a history, find out what the presenting problem is, evaluate the history of that, evaluate the social and family history of the person, find out about previous diseases, family indications of disorder, do a mental status examination, do a physical examination. This is standard practice.

Q Certainly.

A This is built into the training of the professional that this is the way you work. This is the way you do the job. And, I think that probably all the hospitals do have some [105] sort of, maybe not written as policy, but just the format that exists. These are the forms, you know. You fill these forms out. They have a policy on filling out forms on an emergency basis, what has to be filled out promptly after that before the first staff conference. Okay, we let this patient in. Here's the picture we have.

Q All right, I appreciate what you're saying, that an individual, specific individual, admitting psychiatrist in a hospital will draw on his professional background in order to make that decision. But, what you've said is you would assume that each hospital might or might not have policies that are written down that might help, in other words, that help that particular psychiatrist.

A I would assume that they all have some sort of procedure manual that sets out some kind of standards.

Q Right.

A On this.

Q That would be determined by each regional hospital?

A Yes.

Q As opposed to having like a statewide book.

A Right.

Q As a set of regulations.

A Yes.

Q Okay. One other point that you made—

A I am also sure that as we move ahead with the system [106] that the state office is going to be making periodic reviews of those and may come up with some policies, if it turns out that some hospitals aren't coming up with what we consider adequate standards.

Q You spoke of, again when questioned about the possibility of a hearing, the effect of a hearing of airing dirty linen. Might also there be another side to that in terms of clearing the air, if you will, rather than masking family difficulties or being therapeutic in that both sides of the story might be told?

A I would sure a lot rather do that in a more therapeutic environment than a hearing.

Q Okay.

A With bunches of people sitting around. I don't know how many people you're thinking of. Even 2 or 3 extra people will—the risk that there might be somebody over there behind that mirror looking would get in the way of people's being able to communicate. As back in the days when I was on the faculty of the medical school or a resident in psychiatry and took the medical student into an interview with me some time. This took very careful

work to clear the air on what right that person had to be there, what role they played and the confidentiality of what went on and so on in order to get people to be able to open up to things and talk about them. There was a marked discomfort.

[107]

Q You mentioned you thought a hearing might be disruptive. Wouldn't it also be a serious disruption in a child or an adolescent's life to be hospitalized?

A I think I've said that.

Q I just wanted again to confirm it.

A Yes. It's a serious disruption in a child's life to have a disorder.

Q Are children and adolescents, again speaking of what you're aware of in terms of statewide regulations or variations among each of the individual 8 regional hospitals, are they admitted under a specific time limit category, in other words, for a set period of time?

A I think in all cases, and the hospitals are now trying to make a particular statement, assuming after admission, as to how long they think the child will need to be in the hospital. As a generality, probably the programs we're able to offer in regional hospitals are most appropriate for kids to come in and stay not more than 3 to 6 months. To organize a program that can serve as a long term continuing useful service at the same time that is providing for a fairly reasonable rate of turnover to deal with the acute situations almost requires two different organizations. And, so in general I would say where we are at this point, 3 to 6 months might be the general range that we would aim to contain it within. There might be particular

cases where beyond that and [108] up to a year would be appropriate.

Q Are there any statewide either regulations or policies within individual or any of the 8 regional hospitals for informing children and adolescents of their rights as voluntary patients under the specific Georgia code sections?

A Yes, this is standard.

Q Could you describe—

A The—No, I can't describe in detail. Just before I arrived here, the Advocacy Section of the Division Office had to file a rights statement for adult mental health patients in the hospitals. And, this little booklet is available, and as I understand it, is routinely provided to patients when they come into the hospitals. It's available in all of the units and so on.

I think there has been some attempt to use this with children, and it's not written in children's language.

Q Okay.

A But, the staff are well aware of the issues involved and the rights.

Q Would a child—

A The rights booklet—are expected to inform children of their rights.

Q Orally inform them, you mean?

A Yes.

Q Okay.

[109]

A Now, those rights at this point include rights to have their clothing, rights to make telephone calls within

reason, correspondence, various and sundry things like that. For children at this point we don't include the right to leave the hospital until parents say so, until the hospital and parents agree. In that sense it's different from adults.

Q Specifically, concerning the right to discharge, in other words—

A Yes.

Q When a child—Would a child be told then what you explained to me that should his parents consent and the hospital also decides he should be released that he would be released? Is that approximately what he would be told?

A I couldn't say. I don't know that that is actually conveyed to any child in that specific detail.

Q Again, we're not talking about a written regulation; we're talking about an understanding of what your understanding of what would take place.

A I guess what would come closest to regulations is what's in the law on that.

Q I'd like to show you something. This is a notice to voluntary patients of rights to discharge. It's dated November the 4th, 1970; and it's to J.L., one of the main plaintiffs. It's Exhibit Number 3 to the stipulations of facts.

[110]

A Should I read all of it?

Q Well, I just wanted you to glance at it. The named plaintiff, one of the named plaintiff's in this case, J.L.; note there's a signature down at the bottom of that page.

A Uh-huh (affirmative).

Q By the name plaintiff. Do you feel—He was 7 years old at the time he wrote that. Do you feel he could understand that?

A No.

Q Okay. You mentioned the children's rights, in other words, a right to discharge would be conditioned on a consent of their parents.

A If a child is in the custody of the parents, yes.

Q Assuming that his discharge is conditioned on his parents' consent, and his parents don't want him and refuse to take him, what position is the hospital in at that time? And, again assume also the hospitalization is no longer required for this child, that that's the uniformed consensus of the hospital personnel that are directly involved. What would the hospital then do?

A I think probably the most appropriate thing the hospital would do would be to seek to have custody removed from the parents, if the parents are inflexible in their attitude that they're not going to take the child back. Probably also the hospital staff ought to be in some cases [111] sizing parents up and say it would be disruptive to send this child back to the parents in whatever we might be able to do during the time the child's been in the hospital, it might at times be appropriate for the hospital to raise the issue and initiate proceedings to have custody removed.

Q Specifically, what person in the hospital—Let's assume a situation like that existed, and you said that it would be appropriate for the hospital to check into having the parents' rights terminated, what person would be charged with that responsibility, in other words, to initiate action?

A I suppose it would be most likely the director; within a particular hospital they may choose to have somebody of a high administrative level take responsibility. The unit director might delegate it to a social worker or something of this order. I would think the director would probably be the focal person.

Q Would that unit director have any guidelines or memorandum directives that would speak to his role or the role of another person within that hospital structure that would say, "This is what you should do, you can do in this instance to initiate this, contact this person."

A I don't know of any guideline statements.

Q Is it your—Go ahead; excuse me.

A This is almost a new issue, because of the history of where the hospitals have been and so on. A conservative [112] view about disrupting family relationships which has been promoted by the courts and all sorts of people, mental health people have not been in the forefront of perhaps of coming out and saying, "We ought to break up families."

Q You mentioned the possibility in the future of developing guidelines for periodic review. You touched on that briefly before. Would you elaborate on that, in other words, what you anticipate.

A What I anticipate is that the division will—I think Doug Skelton has already sent out some requirements that the hospitals have periodic review practices and policies. I think probably—I think they all do. I'm sure at some point the division will be reviewing all such policies and exploring whether they seem sufficient, whether we need a general formulation from the state about such things.

I was involved, as I mentioned earlier, in the developing of a policy in confidentiality which has been blocked from being put into effect because the Department of Human Resources was behind us in developing a department policy in confidentiality; and they didn't want to have us put one out that would be out of line that would come out as a whole department policy. At some point in the near future I hope they may get clear enough on where they want to go that ours is going to go out as a department policy on confidentiality. It deals with it in some very broad general [113] terms, but has specific requirements that each hospital, each unit, each mental health center have its own policy and its own practices within these general guidelines for effectuating a confidentiality policy and seeing to it that all staff are informed adequately in training in regard to confidentiality. And, I'm sure we'll be doing similar things with utilization and review.

Q Is there anyone who acts specifically as an advocate for the rights of children and adolescents in state mental health facilities within the Division of Mental Health?

A We have an Advocacy Office that has responsibility to respond to any advocacy issues in regard to any patient.

Q In other words, their responsibilities go to the entire patient population.

A Yes.

Q How many people are within the advocacy unit that you mentioned?

A Three.

Q Is there any recourse or remedy for a child or adolescent who believes that he or she has been inappropriately committed? In other words, is there anything that

he would be informed of or any regulations, specific hospital or statewide regulations that you are aware of?

A The rights booklet.

Q The rights booklet.

[114]

A Which is not written in children's language and, therefore, hasn't been as useful in child and adolescent services as adult services. It includes the advocacy unit as a resource that any patient can call on. To the extent that the child is able to understand either the booklet or the verbal interpretation that's given to him, the child knows of the advocacy unit. He knows of his right to call on them.

Q At present are all diagnostic procedures conducted on an out-patient basis?

A No.

Q Okay, how—At present have you or your division ever recommended a change in the child and adolescent voluntary admission statute? In other words, any of your predecessors or are you aware of anyone else in the past within the Division of Mental Health who has made such a recommendation that there be a change in this particular statute?

A I'm not aware of any, no.

Q Are you aware of any reports by any dependent bodies or anyone within the division that address the issue of the appropriateness of a "voluntary" admissions statute for children and adolescents?

A The only group that I think might have done that would be the Child and Adolescence Study Commission which functioned, I think, in '73 or '74 for about 6 months

and [115] made quite a large number of recommendations. I don't recall a recommendation with regard to changing the statute being among the recommendations. But, it might have been. I can't say it wasn't.

Q Do you remember any of the report that you just referred to—Do you recall any of the recommendations that were made by that commission at that time, specifically, that stand out in your mind?

A In general I would recall several, I think. One that stands out clearly in my mind was there be no further development of the community system until a lot more study had been done, which struck me as the most asinine recommendation that I've ever heard of in my life. Here they were talking about improvements in the hospital system but blocking any further community program development—and completely ignored that recommendation.

Others were primarily focused in some cases in rather microscopic details about hospital services; that there be better work with parents of children in the hospital; that there be—I can't say I recall others in specific detail. I know I have reviewed it a couple of times since I started in this position. And, I've seen we've made considerable progress on a number of points. I haven't reviewed it—

Q Can you be specific about the progress that's been [116] made on the number of the points that they raised since the time the report came out, specifically with relation to the points in the recommendations?

A No, I can't.

Q Okay.

A We have significantly reduced the hospital—We

have higher staff-patient ratios, because of the less patients. We are providing much closer working between the hospital and the community system with a lot more continuing work with the parents of children who are in the hospital.

Q Okay, were you aware of any of the findings that that particular commission made in that report regarding the population, the patient population of children and adolescent units statewide?

A I have examined the report.

Q Are you familiar with their finding of the similarity in the types of behavior that led to hospitalization and state mental facilities with the types of behavior exhibited by youths who were involved with the juvenile court as juveniles, excuse me, as delinquents and status offenders?

A I am aware of that as a general consideration. To say that I remember it from the court, I can't say.

Q Were you—

A It's a truism that probably applies to most everywhere in the country.

[117]

Q Okay. Were you aware of the finding that that commission made as to the percentage of children and adolescents that were hospitalized that either had no family or a severely dysfunctional family or in state custody?

A I examined it. At the time I was aware of it.

Q Going back just for a moment to diagnosis. Is it possible for a psychiatrist to err in diagnosing a child or adolescent, in other words, in their concluding he was so seriously mentally ill as to warrant hospitalization or institutionalization. Is it possible?

A Yes.

Q Can the orientation and the training of a psychiatrist have any effect on his diagnosis to make the determination of mental illness?

A I'm sure it can, yes.

Q Are there different schools of thought as to mental illness concerning cause and cures which may strongly influence psychiatric judgment? In other words, is it possible that a psychiatrist would—Do you see what I mean?

A I'm not sure I see what you mean. There are different schools of thought that would lead some psychiatrists to say the only way we're doing any good is if we do it on a very long term intensive treatment and to reject and derogate any treatment that doesn't fit that pattern.

There are other schools of thought that would say [118] the reverse. There are other ways that are important.

Q That's what I was getting to. Can the context of a psychiatric evaluation have an effect on the diagnosis? In other words, if the diagnosis was being made let's say in a community treatment clinic as opposed to right within the hospital itself, can that have an effect?

A Yes, I'm sure it can have some effect. I think since most diagnosis is based—Well, the diagnosis is not finally assigned until a significant amount of time has gone by and a fairly complete evaluation is made. You may make a preliminary diagnosis.

Q Uh-huh.

A And, that might be conditioned by the circumstances under which it's made. But, within a particular school of thought when an adequate evaluation is done, I

doubt that it would make—well, a fairly small amount of difference.

Q Does a single unstandardized interview by a psychiatrist—the results of which assuming a psychological testing supplements—present an adequate sample of this person, of his possible potential patient's behavior?

A In some cases it can be an adequate sample for at least initial decisions. You're asking a question that is just as applicable in general medicine.

Q Okay.

A When you take a history; you do a physical exam; [119] you do preliminary lab tests. All that may indicate is that the person needs to be in a hospital for much more extensive testing.

Q Okay. Is it possible that a psychiatric judgment may be influenced by the socio-economic background of both the doctor and the patient, the doctor's value system, personal preferences, these types of things? Is it possible that they would influence a decision?

A There are some good studies in the past that have pointed very clearly in that direction. There have been some more recent challenges, recent questions as to how true it is. I think it's possible, yes.

Q Based on the questions and the answers you have given to these last few questions, considering the factors that we've discussed that might influence particular doctors, isn't it possible that doctors could disagree on, for instance, the severity of a mental illness or the label of a mental illness that would warrant hospitalization?

A Yes.

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR LUCIANO L'ABATE, taken on the 15th day of December, 1975, in the offices of Georgia Legal Services Programs, 15 Peachtree Street, N.E., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

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[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The witness was advised of his right to read and sign his deposition, and he specifically waived that right.)

DOCTOR LUCIANO L'ABATE, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MR. GOREN:

Q Please state your name and address?

A My name is Luciano L'Abate and I live at 2079 Deborah Drive, Atlanta, Georgia 30345.

NOTE: (Plaintiff's Exhibit Number One was marked for purposes of identification.)

Q Can you identify Plaintiff's Exhibit Number One?

A This is my curriculum vitae.

Q What is your profession?

A I am a teacher.

Q And could you describe for us essentially—excuse me, what do you teach?

A I teach psychology in the Department of Psychology at Georgia State University. I'm also Director of the Child Development Laboratory in The Family Study Center, and I'm Director of the Family Study Program — the Ph.D. Family Study Program in the [3] Psychology Department of Georgia State University.

Q Okay. Are you also in private practice?

A Yes, I'm also in private practice . . . and I practice mostly of marital and family therapy.

Q What is your educational experience?

A I have a Ph.D. from Duke University and a Post-Doctoral Fellowship with USPHS—United States Public Health Service, at Michael Reese Hospital, Psychiatric and Psychosomatic Institute. I have been essentially working in a hospital—in hospital-like places since I was graduated from college—from Tabor College in 1950. I worked for a whole summer as an attendant in Canadian Psychiatric Hospital. Then during my work toward a Masters Degree at the University of Wichita, Wichita State University, I worked as an attendant in a psychiatric ward of a general hospital, Wesley Hospital; and since then I've been associated with Duke University School of Medicine, Michael Reese Hospital, Washington University School of Medicine, Bernard Hospital, which is the psychiatric hospital. From 1959 through 1964 I was consultant to St. Louis State Hospital, which is a state psychiatric hospital in Missouri. I was Chief Psychologist, Department of Psychiatry at Emory from 1964 to 1965. From 1965 through 1973 I was Director of the Psychology Laboratory in the Department of Pediatrics at Emory University School of Medicine. I've been in my present position at Professor of Psychology at Georgia State since 1965.

Q Okay.

A In 1965, and since then, I've been consultant to Alto Juvenile [4] —Juvenile Institution for First Offenders, I've been consultant to various school systems, various private schools, and hospitals, and I'm presently on the current staff of Tucker's Doctors Hospital.

Q Have you had any publications or articles?

A Yes, I've had a few publications, and they are in this list here.

Q In your vitae?

A Yes.

Q Have you had any articles published specifically referring to children?

A Approximately fifty percent of my articles deal with children. In the last few years, I've had fifteen, twenty publications dealing with children and the family mostly. I've recently published a book, Teaching the Exceptional Child, which is a standard textbook in colleges in the United States.

Q Okay. In your experience have you ever been called upon to observe and evaluate a child's behavior in regard to his or her parent's request for help and possible hospitalization?

A Hundreds of times, and in my practice I've evaluated upward of approximately five thousand children.

Q Is it your experience that problems which lead parents to seek hospitalization of their children can be traced to family difficulties and not just the illness of the child?

A Well, it depends on the nature of the illness. If you're talking about a severe organic problem or in terms of extreme retardation, in some cases I—especially if it's clear that the child not only detracts from the family's function and ability [5] as to the stress, clearly that might, in some cases, be relevant of hospitalization. Outside of these very extreme conditions, I don't consider hospitalization as a viable alternative.

Q You think that family difficulties have something to do with these other problems with the children?

A Well, one way or another, all of us live in a context, and to deny that context, which is the family, I think, is a grievious, theoretical, emperical, clinical mistake.

Q What types of dynamics exist which could contribute to psychiatric problems of children?

A As I see it, in terms of what the outcome I've seen, in the kinds of cases that I've studied over the years, seem to be based on the parents inability to deal with their own selves, and their own marriage, so that they—either inadequate or the relationship between themselves, which is their marriage, makes it very difficult to deal with a child, and if they do deal with a child, they deal in inappropriate ways, mostly negative, it will eventually produce negative behavior on the child, because that's all he has learned.

Q Are you familiar with the term scapegoating?

A Yes.

Q In what way, if any, do you see that or any other types of interactions relevant to a child's psychiatric problems?

A Well, I see scapegoating as based on mechanism which I personally call externalization, which I think has experimentally been found in a work of a social psychologist, especially I refer to the work of Duval and Wicklund, which published in 1972, and they were able to find two different kinds of awareness. One [6] they called subjective awareness, the other one they called objective awareness, and they discovered that fairly well consistently people see two different—these two kinds of awarenesses. The objectively aware individuals are able to see themselves as part of any kind of interaction. The subjectively aware individuals are individuals who cannot seem to realize the impact on others. And their work pretty well would seem to agree with hundreds of studies done by a fellow called Witkin, which divides individuals between feel dependent and feel independent, and the work of another psychologist called Rotter, who talks

about internalizers and externalizers. And essentially they seem to be talking about the fact that there are individuals who really are externalized in most of their perceptions, most of their behavior on outside sources and outside targets, so my general feeling, which is—theoretically, I think, can be empirically demonstrated. Most of the parents of children who have problems are individuals who will fall in the category of subjective awareness. They don't seem to have an awareness that they have an impact on a child, the child's behavior or pathology is in some-way related to their own pathology.

Q When you're going to evaluate a child's mental condition, who is the primary source of information on the child?

A Well, let me think—I think that's an important question. Let me answer in terms of the fact that for twenty years I did just that, evaluated children, and evaluated hundreds and thousands of children as a child clinical psychologist. My awareness, in working with children and doing therapy with them [7] as individuals, and by-passing the family, and not obtaining results, got so extreme that I finally quit doing what I was traditionally doing; that is, evaluate a child and then report the results to the parents, because I found that I was part of what I would call a collusion, the collusion that the parents had in making the child the scapegoat, making him what is called the identified patient. And before I was agreeing with them by evaluating him as a patient, I was agreeing with them in that he was the problem. Since 1972 I have pretty well quit evaluating single children, and I only will evaluate the child with the family, and if the family is not willing to come in as a whole family, that is children, siblings, and so forth, I will not see that child. So I have

drastically revised my practice. This is why from child clinical psychology practice I am now working mostly with the family or the parents. That is why I am a marriage and family practitioner.

Q Who is the primary source of information about the child when you are going to work with the family?

A Mostly the mother, is mostly the major source of information.

Q In getting these principles of subjective awareness that you described for us, could those circumstances cause a mother, or both parents, to mask their true feelings and distort or misperceive facts concerning their child?

A Very much so. I don't only think just the parents do this, I think there is plenty of research to indicate that many people who are interviewed, including schizophrenics, will very much depend, because of the feel dependent orientation of people who seem to be more vulnerable to mental illness, that they [8] will look at cues into the interviewer, and they will try to fit and please the cues the interviewer gives, and I suggest the work of the Braginskys — Braginsky, Braginsky and Wren, 1969, that indicate that's a process that goes — that is present in many interviews; that is in many cases the clients want to appear sicker than they really are, especially at first blush, which is usually the first interview. So there seems to be assets, for many people, and the parents of children who have problems do not differ in terms of wanting to make the child sicker in some cases than he is.

Q Okay. In trying to ascertain what is really going on in a family situation, given these problems that you've just described, is it difficult for mental health professionals

to try to understand exactly what the true facts are in a given situation?

A Yes, it is difficult. In some cases it takes years, to work with the family, to get all of the information. This is with most cases, treatment consists of finding—I would not call facts, but all of the various relevant skeletons that there are in a closet in which many families keep very, very close locked door on.

Q Would these difficulties be increased if the person who is doing the evaluating had difficulty with the language of the—say the child, or the family, that the person evaluating—or was not familiar with the cultural background of the person that he's evaluating?

A Well, all I can think about is my experience, and I know that I clearly see a certain kind of families, and I am more successful with some of them than others, and I would presume if they are [9] middle class American Protestant, as an Italian Protestant, I would say I have much better luck working with them, than, I'd say, if it were some other kind, so clearly there is a great deal of research to indicate that the closer the similarity between the therapist and the client, that the better the chances of therapeutic success. So there is a similarity factor in there too, which indicates that I would be very unsuited, and I'm sure I am, to work with certain kinds of families.

Q Okay. In your experience, have you found that it is possible—that there will be occasions, when, for the best interest of the child, he or she will have to be removed from the home?

A If four or five different other kinds of things fail. In other words, I see the removal from the home for whatever reasons, whether it's foster home or hospital, as being the result of extreme failures of trying other methods, and we do have at this point, a significant technology of a variety of procedures that can be worked out, so I found, really, no excuse to jump from a child in a home to away from the home, unless four or five different possibilities have been explored, and there are many of them.

Q Are you saying that these possibilities ought to be explored before hospitalization?

A Definitely. Definitely.

Q What kinds of possibilities?

A Well, first of all, the reports from teachers working in the school, the classroom with the parents learning how to manage the child, behavior modification procedure, to train them to use positive rather than punitive approaches, structural methods [10] of dealing, of enrichment of methods that we have developed to work with families, of classes for the parents to take with other parents, like P.T. There is a tremendous amount of preventive approaches that are available these days, that parents can be and should be in a way forced to take if the alternative is clearly, you know, take the child away. Before you do this, the parents should be forced, in a way, to partake and learn more about what it takes to be parents.

Q Suppose there is a situation where those types of things have been attempted, is then the next alternative hospitalization?

A It would be very difficult. It would depend on what alternatives, with whom and so forth. It could be, but it seems to the hospitalization, in terms of the work of Skeels, it's really, to me, like a sentence of death. I think Skeels' work clearly indicates, in his follow-up of children who were hospitalized and children who were not

hospitalized, very clearly indicated, that if we hospitalize infants or children, the outcome is going to be really, diliterious, and that it's better, let's say, to put children in foster homes. So for instance, if you had another choice in terms of taking a child away, well, then, it would be that the child would be in a foster home, and hospitalization be, let's say, the outcome of failures in fostering, in taking care of the child, or even halfway houses or cluster homes. We know that the whole State of Tennessee, for instance, has been able to do away with hospitalization through the model of what they call the—the rehab model, so that that work, I think, is important [11] to indicate that hospitalization should only be the result of failure in a variety of alternatives, that we have in many, many cases failed to explore and use to the fullest extent.

NOTE #300

Q Okay. Do you believe that because of problems that may be within the family itself, the parents can at times act against the best interest of their children in seeking their hospitalization.

A Oh, I think there's enough literature to support that. If we all take the literature on the battered child syndrome we realize that, first of all, it does happen, and secondly, that of course unfortunately many of the battering parents were battered children themselves, and I think there is pretty much that kind of vicious circle involved in—in many parents have been unable to become full-fledged parents and know how to parent, because they did not have any better parenting themselves.

Q Is it also possible that parents may seek to hospitalize their children, and that that hospitalization would be against their best interest?

A The parents? It seems to me it's evident, because first of all, my accepting a child in the hospital or taking

the child away, we are agreeing that that child is a patient. Well, by doing this and agreeing with the family, we're essentially colluding with the family, and we are agreeing with them that if the child's behavior changes, the family will be okay. Well, to me that is the position that is logically and emperically impossible, because, what we're really saying is, if the child is a product of a system, which is the family system, then the whole system [12] has to change together with that child. However, if we take the child away then we're also agreeing that the system will not change. And this is what I've seen for twenty years, and this is why I finally gave up my practice of dealing with the child. When I took the child in treatment, the rest of the family said we're okay, they took that communication to represent that we're okay. When I confronted the rest of the family, "Hey, this family has to change," the . . . says, "Now wait a minute, he has to change, we don't have to." And so hospitalization without attention to the family, is a red herring. It's a . . . We agree—we agree with the family that the child is the patient, is the problem and that they should not be considered.

Q Okay. Do you have an opinion in regards to whether or not mental health professionals can make errors in recommending hospitalization of children?

A In terms of emperical data—in terms of the specific problem of hospitalization versus non-hospitalization, I don't know that we have data to support it. I do know that we have hundreds of papers of a hundred diagnostic witnesses we have in our every day life, so I am perfectly aware of the fallibility of our diagnostic labels, our own diagnostic tests, and in many cases our tests that we use in clinical psychology are not better than the criteria we

use, which are mostly psychiatric diagnosis, and realize that any time we have that kind of criteria in our tests they are really not very good.

Q Are there any tendencies that may be inherent in screening done [13] by mental health professionals which, for instance, may cause them to over-diagnose mental illness?

A That is definitely one of the major aspects, especially in psychological reports, many content analysis is made of psychological reports indicate that we tend to over-emphasize liabilities and limit the assets.

Q Were you present at Daniel Offer's deposition?

A Yes.

Q And are you also familiar with his work of the Psychological World of the Teenager?

A Yes, I reviewed it in General Personality Assessment, 1970.

Q What is your opinion of his statements in that book and his testimony in regards to the voluntary commitment of children in mental hospitals?

A I'm sorry, but I really fail to see the significance of that work in terms of the issue of hospitalization. His sample was drawn from what I would consider forty-eight percent or fifty percent of the population, that was the middle class population. That means that any of these figures that are present in this book, have to be halved—cut in half, to have any kind of statistical significance, so that if he says there are three types of adolescents, well, first of all he eliminated out of his sample twenty-three percent of the adolescents that would have troubles. Well they were not part of his book. Well, these are the kinds of adolescents that indeed would have trouble and would

come up for some kind of psychiatric or mental health evaluation. The other three [14] kinds of adolescents that he describes, the continuous growth, surgent and tumultuous growth, which have twenty-one and thirty-five, I think, and twenty-one percentage of his sample, in terms of the fact that he took a sample from fifty percent of the population clearly indicates that any kind of generalizations can be made from those samples as to half of the total sample. In other words, any kind of conclusion he makes in terms of the general population, would have to be—if you take—if you total that up you get seventy-seven. Well, actually half of that would represent any kind of generalization for the general population. Furthermore, it would not address itself to minority groups except—it says fifteen percent for his sample. But lower class was eliminated, upper class was eliminated, so there are a variety—well, it's clearly urban sample, so despite all the problems of mental health of the adolescent, that book, in my personal opinion, seems to be irrelevant to the issues.

Q Are you saying he also found that twenty-one percent of the group that he studied exhibited adolescent turmoil?

A Yes, in fact he did consider that the tumultuous group, which is his third group, which had tremendous ups and downs, also had twice as much counseling and psychiatric referrals as the next group, which was the surgent, which was the major thirty-five percent, with the continuous grow group of twenty-one almost have no referrals whatsoever.

Q And in spite of this high and low swings that he described for this group, he still considered these boys to be normal, is that correct?

[15]

A Yes, indeed. Yes.

Q Do you believe a hearing prior to commitment is necessary for the non-emergency admission of a child to a mental hospital?

A I think it would be helpful. It would be certainly, at this point, as things are, imperative.

Q Why is that?

A Because I feel that as things are, the best interest of the child lie in due process, and if there is no due process, that is if there's no attention to the child's rights, I don't think that even the mental health profession are aware of what these rights are, and in many cases due process is not really followed. In some cases attention may not be given to distortions in the parents, possible biases in the mental health personnel, especially as if they have an investment in filling the hospital beds. If state allocations are made on a basis of how many patients are there, or how many criminals are, then we're dealing with a system which has an investment in numbers of people admitted, and I as a teacher, have an investment in people coming to Georgia State, because if there were not enough students, I would not have a job. So it seems to me that people who are in hospitals, and work in hospitals, have an investment in having patients, and that in itself, is to me a fact that speaks for itself.

Q How do you think a hearing could be beneficial for a child?

A Well, first of all there would be safeguards of complete evaluation. If we're talking about a successive . . . kind of approach that is various alternatives, then you have all the [16] information of people who have been

involved with the family, let's say a study of the family, of the home situation, a history. There would be a variety of mental health professionals, not just one or two single ones. There would be different professions present. There would be the history of the attempts to deal with that child and the family with all of the possible failures, so that we would make sure that various alternatives and various . . . be present, and the people who have participated throughout the process be there to address to the issue of hospitalization. So that at this point, then, the hearing would guarantee that a variety of viewpoints be heard, which in a way would correct the children, so that there is the guarantee of checks and balances which at this point, as far as I know, is absent.

Q Is it necessary for a child to have an advocate?

A I think it would be extremely important. I'd like to bring to the attention the book on Child Clinical Psychology by Williams and Gordan which I have reviewed recently, I think it is still to come out of the press, in which this viewpoint of advocacy for the child is very strongly emphasized by most of the authors in that book.

Q Do you think that, for instance, personnel who work for a state mental hospital or who work in a state mental health clinic, could act as advocates for the child? Or would it have to be someone outside that system?

A Oh, I would say they should have somebody outside, because [17] clearly we are as limited aspects of our own profession as any profession is, and I would certainly feel much more comfortable if the legal aspects, the rights of a child, be safeguarded by a non-mental health professional.

Q Okay. Do you think that even if a child is deter-

mined to be in need of hospitalization, that it's necessary to have a periodic review by one independent of the hospital?

A Well, this, I think, would be part of the process, if there is an advocate which is not mental health oriented, then he would not only be objective, but he also would make sure there would be a periodic review. I think that this is one of the frightening aspects of hospitalization, that once the child is put behind doors, he is forgotten, and is forgiven, and that trauma at that point is really followed by the trauma that perhaps nobody else will care for him, and no matter how therapeutic the hospital may be, some link to the outside world still would be very important to have.

Q Have you had—I believe you mentioned you worked at Alto, is that right?

A Yes.

Q And therefore you are familiar with the behavior of persons who have been labeled juvenile delinquents?

A Yes. I also worked as a consultant to Coweta County public schools where I was given to work with the most serious offendant in the system—the school system, in addition to Alto. (sic)

Q Okay. And have you been made aware of any situations where parents [18] filed petitions in juvenile court to get help for their children whom they consider unruly or incorrigible?

A I'm aware there must be some kind or process. Actually, I'm more aware of the fact that the parents will let go many situations until the child is in so much trouble that he himself will call attention to the problem. To me

that is the—most—most of the process is done by omission rather than the parents themselves committing the child. They'll let the problem go until the child gets in trouble.

Q Have you been able to compare the behaviors of persons who are labeled juvenile delinquents with the behavior of persons or children who are labeled mentally ill?

A The only thing that I see that kind of behavior, is that the mental illness manifested itself in criminal behavior. In some kind of social strata that will bring attention to the police. In the middle upper class youngsters I've seen and I still see in my private practice, there is some protection in a sense that if the police picks up the son of a middle class white child, they will probably try to protect that child in many more ways that just putting him into the legal procedure of declaring that child a criminal.

Q Do you see any similarities between the types of behaviors that lead one to be labeled mental delinquent and one labeled mentally ill?

A Anytime I examine, and I've examined, I forgot how many juveniles at Alto, everytime I examined them, if I had been blind to the fact that they were in an institution, I would have probably agreed to put on them some kind of a psychiatric diagnosis.

[19]

Q So there are similar behaviors?

A Well, if they are not similar, there is a tremendous overlap.

Q I have no further questions.

EXAMINATION BY MS. KIRKLEY:

Q Are you a consultant at Alto?

A I was for a year.

Q Alto is not for juvenile delinquents, is it? Isn't it for youthful criminal offenders?

A Yes.

Q Sentenced by the Superior Court . . .

A Yes.

Q . . . rather than juvenile delinquents sentenced by the Juvenile Court?

A I am not familiar with all these aspects, but I know they were criminals, yes.

Q Okay. I think as you reviewed your private practice in the last few years, perhaps since 1972 explicitly, you said that you had started to look at a child in the context of his whole family and to threat the family rather than just one individual member of it?

A Uh-huh. (Affirmative.)

Q Do you have any evidence that the Georgia Public Mental Health System treats the problems of children any differently than you do?

A The only knowledge I have is that most of the—that some of the system in some cases, follow the tradition of team approach, in which you have a psychiatrist, a social worker, [20] and a clinical psychologist in which the child is evaluated, and then a history is obtained from the parents and so forth, so that although I'm aware that in some mental health clinics, the families are being seen, and the identified patient is seen together with the

family, I'm also aware that many of these practices vary from clinic to clinic and from individual to individual. That's the best I can tell you.

Q But you are familiar with the practice in some clinics that try to treat the family?

A Oh, yes, definitely. There is some of it. I'm aware of the fact that at least at G.M.H.I., they still will—in the children's ward, which I visited as recently as six months ago—they still will accept a child individually and not require treatment of the rest of the family, so that, again, they will—they will accept the child but not force—you know, make sure that the family does get treatment too.

Q But do you know that G.M.H.I. has a policy of not accepting the child for non-emergency admission unless there has already been treatment of the family in a community mental health center?

A No, I'm not aware of this.

Q So you are only familiar with respect to the hospital admission decision, is what you're saying?

A Right. Well, what I've seen as I visited and what I asked.

Q What about emergency admissions? Do you see some situations in which children need to be admitted because they're suicidal, for example, and then you would treat the family later?

[21]

A I have not seen many suicidal children, so I really can't say that there was a kind of emergency that I would deal through hospitalization.

Q But you can conceive of situations in which children are so suicidal that that would be a treatment of choice?

A I can't say. I have not seen it. I would probably, before getting that kind of step, I would probably ask the help of some other professional, I would ask a psychiatric consultant to see whether we could use some other medicines or drugs, which I—you know, I don't . . .

Q Isn't suicide a leading cause of death in children and adolescents?

A It's certainly getting to be one of the high reasons for it, yes. We have some of it. In whatever it seems to be the possibility of suicides, and there are very few cases I've seen, it's the ultimate results of a child's helplessness in controlling the family, so I feel that in the midst of the—what seems to be the reasons for the suicide, the child—this is the child's ultimate weapon, to blackmail the family. Suicide in many cases, at least as I see it, is a form of blackmail. It's a very deadly form of blackmail, and many adolescents will use threats of suicide, rather that the actual suicide. Naturally, no family, on the basis of threats is going to not do anything. They're going to try to deal with it, but in some cases, and I can't speak because I haven't seen it that many, I prefer to still deal and take the danger of the possibility rather than going through the hospitalization. In some cases I dealt with suicide with adults, and my answer to that kind of threat is to call the police.

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Q Are you familiar with the drop in the patient population in Georgia's regional hospitals since 1964?

A I am very aware of the drop at Central State Hospital since I have visited that hospital once a year for the last ten years as teacher of my exceptional child class, and so that teaching those classes I wanted my students to become very aware of the—you know, what happened to our children, so I have regularly visited Central State Hospital. My last visit, however, was not in terms of that kind of teaching. I was there as a member of the board and Vice President of Georgia Psychological Association, so nonetheless, I certainly have been very pleased by the changes that have occurred at Central State Hospital, and I hope there are going to be much more, many improvements made. There are many to be made yet.

Q From this yearly examination of Central State Hospital, then, do you have any evidence in Georgia that supports your statement that the budget is allocated on the basis of the number of patients?

A Well, what you do is, if the budget is not allocated on the basis of beds, it's still made on the basis of outpatient clinic treatments, so I would hope that if they—if instead of going to beds, I would hope that the money goes into treating people outside.

[39]

Q All right. But you stated that one reason why psychiatrists might admit to the hospital, was you hypothesized that it might be so that he could still receive his same budget.

A I did not say psychiatrists. I will not judge—make—I talked about mental health personnel. If you would like to go back to the tape. I hope you realize I talked about mental health personnel.

Q Well, don't you know, Doctor, that in Georgia's

regional hospitals only a psychiatrist can make the decision to admit?

A Well, fine, but I'm not going to judge psychiatrists. I don't want to speak about psychiatrists. I think psychologists have as many errors to look at as psychiatrists, so I will not pass judgment on that particular—another profession.

Q Well, do you have any evidence in Georgia to indicate that any mental health personnel is over-diagnosing in order to increase their budget in a hospital?

A Well, in terms of evidence?

Q Uh-huh. (Affirmative.)

A No, I have no evidence. I do have the fact that if —if you look at the hospital beds, what has happened is that any kind of subtractions in beds and people hospitalized in Central State Hospital, as a result they have been sent in the other regional hospitals, so the total number of beds, very likely, has stayed either constant over the state, it's just been spread out. I would presume that if you count all the beds in the various regional hospitals, you are probably going to have the same count there used to be a Central State Hospital when it was [40] the only receiving hospital in the whole state.

Q But you have no evidence that Central State has tried to keep people there?

A No, I wouldn't—I wouldn't talk about that in terms of evidence. I'm talking about the fact that if you have two counts—if you have people—if you have people, you know, who are out working in hospitals as against people that work outside of hospitals, you're going to have two different kinds of viewpoints, people who work in the hospital will probably subscribe to a view that it's necessary to hospitalize people. People outside will view a less custodial and less oriented towards hospitalization. I think that work was supported by one of Offer's coworkers, Doctor . . . who has done the work on ideology in mental health professions, and the ideology refers to the custodial philosophy versus the treatment philosophy. And clearly we do have an investment of ideology depending on where you work.

Q So you then, are not aware that the census in absolute numbers, has been reduced in the Georgia hospitals by five thousand five hundred since 1964?

A If that's the case, I'm very proud and very pleased to hear that.

Q And surprised?

A Not surprised. I've seen the decrease in the state hospital at Central State. I think I was very—when I went in 1964 it was tremendously crowded. But that doesn't mean that the State of Georgia can sleep on its laurals. There's no room for [41] us to be in any way complacent about what we're doing, not in the field of mental health.

Q You reviewed Daniel Offer's book, The Psychological World of the Teenager, is that correct?

A Correct.

Q Would you say that it's an accurate statement, that one of—let me ask you this way. Your review is basically complimentary to Doctor Offer's book?

A Yes.

Q What do you see as the major contribution which his study made in the field of adolescent psychology?

A Well, it's an emperical contribution in a field which

lacks in emperical contributions. If you look at my review you will see that in 1971 I reviewed the whole field of study of adolescent psychology so that—in 1971—so that from a viewpoint of reviewing the whole field that was a definite contribution. On the other hand, most of the study dealt with normal urban middle class adolescents, the ones who really have the least type of problem, or if they do, he didn't include it in his review. By his own admission twenty-three percent were excluded. If they showed any kind of psychiatric disturbance, he eliminated them completely from his study, which I think is unfortunate because then what we have, we have a discontinuous state of affair which he himself admitted. You have the mental health people working with upset adolescents say, well, adolescence is a time of . . . and extreme ups and downs, and his own data that indicates normal adolescence is not the case. I would suggest that that is, in terms of his data, a continuum of [42] adolescence disturbance. I agree with him that adolescence is no more of a crisis than any other crisis, so that if you take the analysis of when people most breakdown, you will see that people breakdown almost throughout their whole life cycle.

Q Well, I think you categorized a couple of concepts that have apparently been held prior to this work as myths. For example the myth of adolescence as a state of inner turmoil?

A Right.

Q You indicate to me in this review that you think Offer's work is substantial in disputing that myth, at least for the whole population. I mean that the myth . . .

A Yeah, you can generalize and say that adolescence is, you know, it's a time of turmoil for all adolescents. What

he found is a continuum. I mean he himself, with the three cases—three groups that he has, continuous growth, he calls it continuous growth, then he has the surgent group, and then he has the tumultuous adolescent, and by his own admission, very likely the fourth group, who represent the extremely disturbed group, so what he found, it was no different from the kind of thing that you find in any kind of population, which is a kind of a frequency distribution . . .

Q But isn't that somewhat different than the traditionally held view which was that this turmoil was a necessary part of adolescence? Isn't Freud's traditional theory that adolescence was necessarily a time of turbulence so that you could . . .

A By his own admission there are many mental health people, psychiatrists, psychoanalysts that still be believe that.

[43]

Q But in your own mind, and in this article, didn't you state that Offer made a substantial contribution to showing that this is not necessarily the truth?

A Yes. On the other hand, I do miss the connection between the relevance of this study and this work to the kind of issues that we've been dealing in.

Q Okay. Do you see any relevance, then, for the diagnosis of psychopathology in adolescents?

A I don't see that his contribution, if it's used—I hope that many psychiatrists or many psychologists will use his contribution to better diagnose adolescents. Unfortunately, again, if you take a family orientation, in some cases the adolescent's problems are strictly related to the problems of adolescence. So I would really feel that the

most relevant references you want for this particular time would be the work of Hans Stierlin. He published a book last year on separating adolescents from their parents and in this particular contribution, his method of treatment and what he talks about, he dealt with wayward, schizoid and drug addicts adolescents. And his contribution, to me, is much more relevant than Doctor Offer's contribution. And his major point is, that in dealing with adolescents, the major question he poses to the parents who use the adolescents as their scapegoat, is the fact that they are facing middle age, and he forces them to deal with their own facing death and middle age, and coming away from dealing with the adolescent. As soon as he does this, he's able to take the child—or the adolescent away from being scapegoated.

[44]

Q From Doctor Offer's book, The Psychological World of the Teenager, the study you just mentioned, and other research you might draw on, would you agree or disagree with the statement that it's almost impossible to identify the normal adolescent from an adolescent with psychopathology?

A Is it almost impossible?

Q Almost impossible to identify a normal adolescent from an adolescent with psychopathology?

A No, I think it's possible, yes.

Q You believe it's possible?

A Oh, yes. I think it's possible. If you have a whole continuum, you will have some extremely well adjusted adolescents, you're going to have some upset adolescents, which is most of us, and then you're going to have extremely sick adolescents. Naturally, what you're going to

have is the extremely upset adolescents you don't even have to examine. Their history, their whole behavior speaks for itself. They either are in jail or Juvenile Court, or in a variety of institutions. The group that you're talking about, the ones in the middle, or the ones toward the right side of the distribution, would be the only ones that there's going to be some difficulty in diagnosis. They're going to be borderline adolescents, and those are difficult. That is the borderline between health and non-health. And as in any kind of diagnostic decision, whether you have an adolescent, whether you have an adult, or whether you have an old person, the borderline between normal and abnormal, those are the difficult ones. So those are going to be the kind of adolescents that it's going to be very difficult to put into one side of the label or not.

[45]

Q But that would be true, I think you said, of any of the crisis periods of life?

A That's right.

Q And so there would not be any distinction between adolescence and crisis periods in adult life . . .

A Or children too, in some cases you have—and the crisis in some cases that you see in children may be in many cases, really the crisis that parents are having. Again, that's why we need to consider the whole system.

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

APPENDIX B

To Defendants' Supplemental Brief

AFFIDAVIT

Personally appeared before me, the undersigned officer, duly authorized to administer oaths, Sally Barr, who states upon oath as follows:

1.

I am Sally Barr, Statistician, for the Division of Mental Health and Mental Retardation, Department of Human Resources.

2.

I make this affidavit on personal knowledge and for use by the Defendants in the above-styled civil action.

3.

I personally prepared the exhibits attached hereto showing the distribution of the length of stay by number of children for each regional hospital and for the State from 1969 through 1975.

[2]

4.

The attached exhibits were prepared from the informations upplied by the hospital superintendents at depositions taken on December 4 and 5, 1975.

/s/SALLY BARR
Sally Barr
Statistician
Division of Mental Health and
Mental Retardation

Sworn to and subscribed
before me this 19th day
of December, 1975.

/s/Carolyn F. Peeples
Notary Public

Notary Public, Georgia State at Large
My Commission Expires April 23, 1979

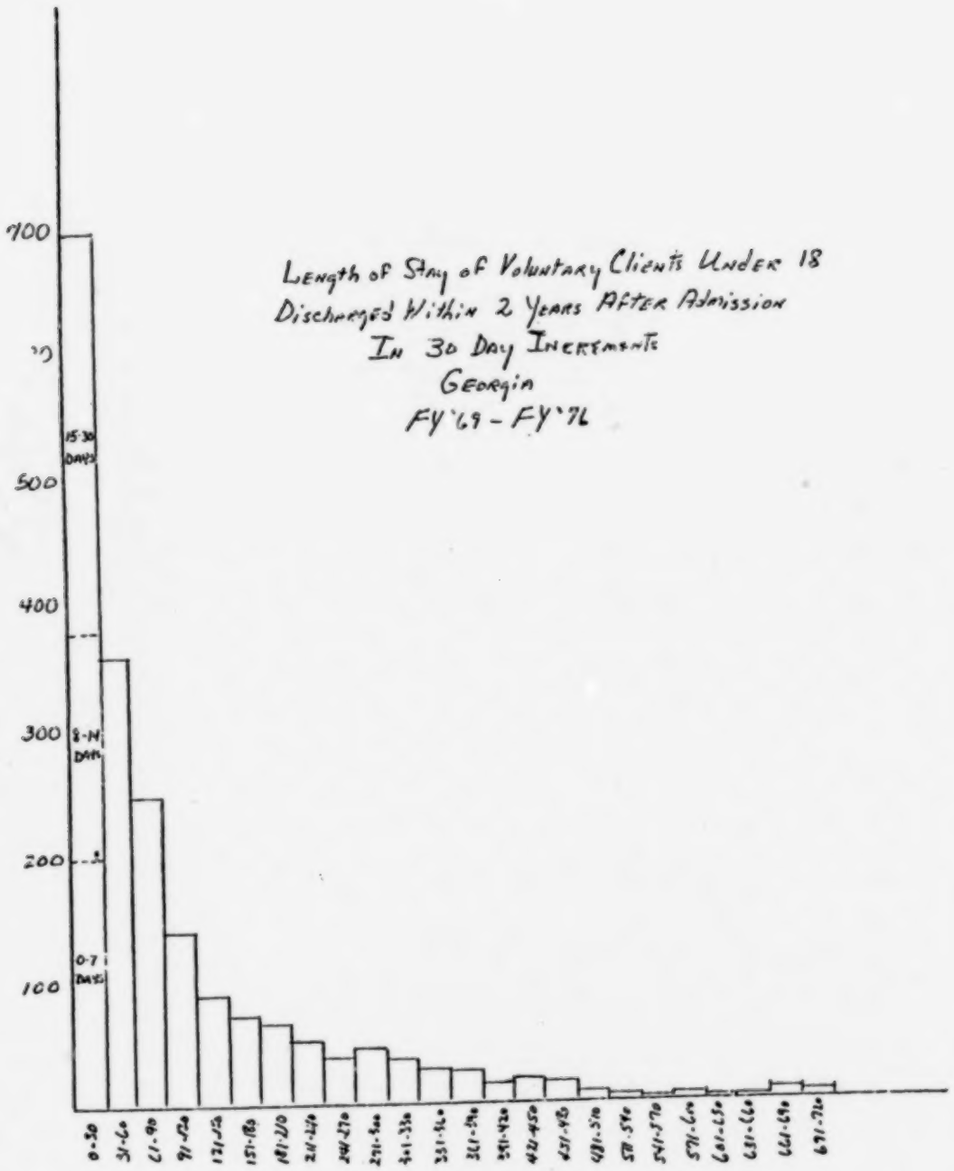
Length of Stay by Voluntarily Admitted Clients Under 18 Receiving Mental Health Services by Fiscal Year of Discharge
Georgia

	Days					Months *								Over 2 Yr
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	
Total	197	178	317	365	245	1302	293	148	101	56	27	13	16	47
FY 69	1			2	5	8	4	3	3		2	2	1	1
FY 70	2	2	2	12	12	30	7	5	5	2	2	1		1
FY 71	4	3	12	11	14	44	27	12	6	4	1		1	2
FY 72	7	12	22	35	35	111	53	26	9	9	2	2	3	9
FY 73	26	34	63	64	39	226	72	46	32	14	4	1	3	5
FY 74	77	54	97	108	73	409	58	24	22	15	12	3	2	17
FY 75	65	57	92	103	56	393	54	30	17	8	4	2	5	12
FY 76	15	16	29	30	11	101	18	2	7	4		2	1	

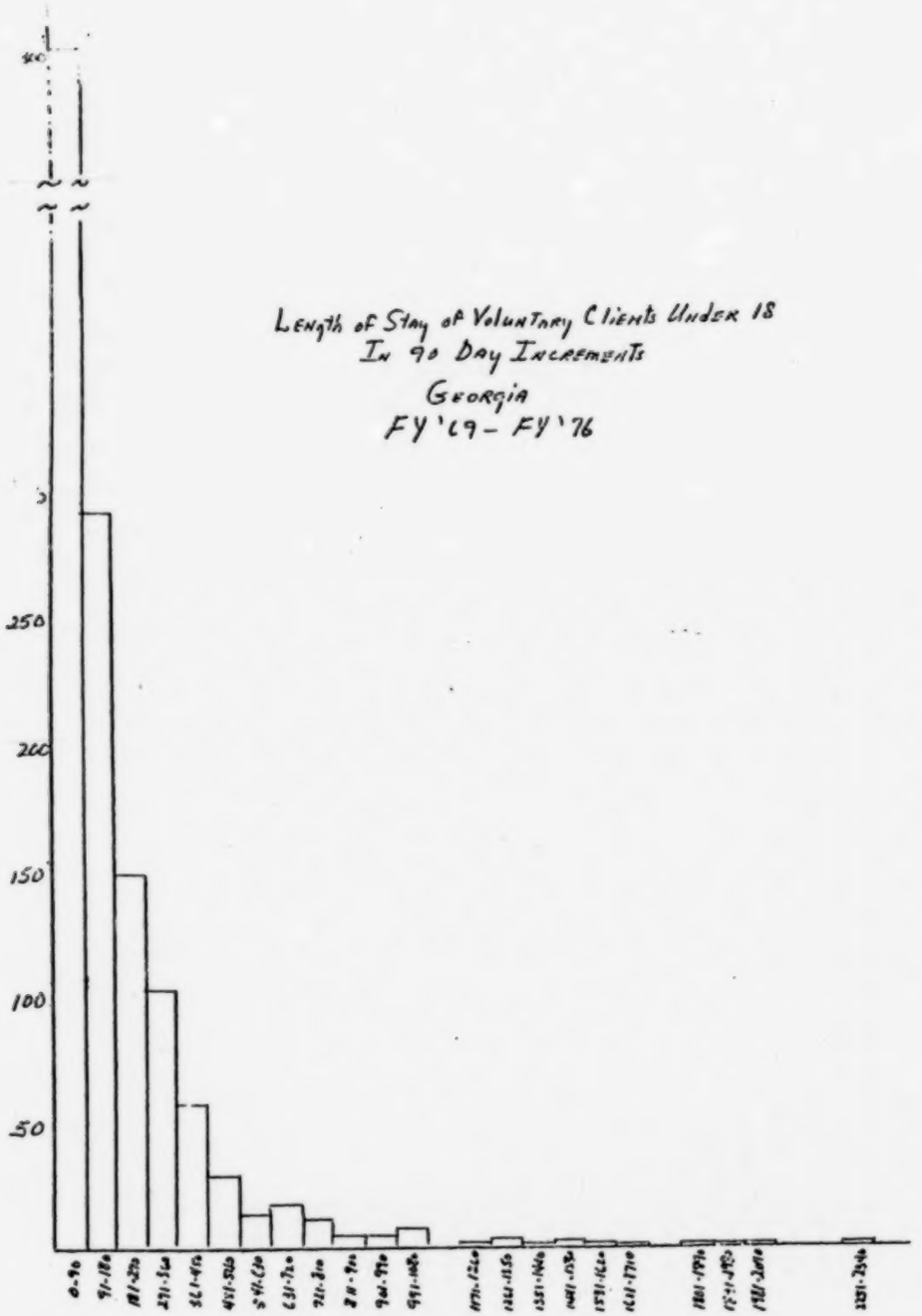
* Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions Of Clients Under 18 to Mental Health Services by Fiscal Year of Admission
Georgia

	Voluntary		Involuntary	
	Number	%	Number	%
Total	2039	65%	1111	35%
FY 69	50	35%	94	65%
FY 70	84	65%	46	35%
FY 71	131	82%	28	18%
FY 72	246	74%	88	26%
FY 73	458	72%	181	28%
FY 74	515	63%	297	37%
FY 75	445	58%	317	42%
FY 76	110	65%	60	35%

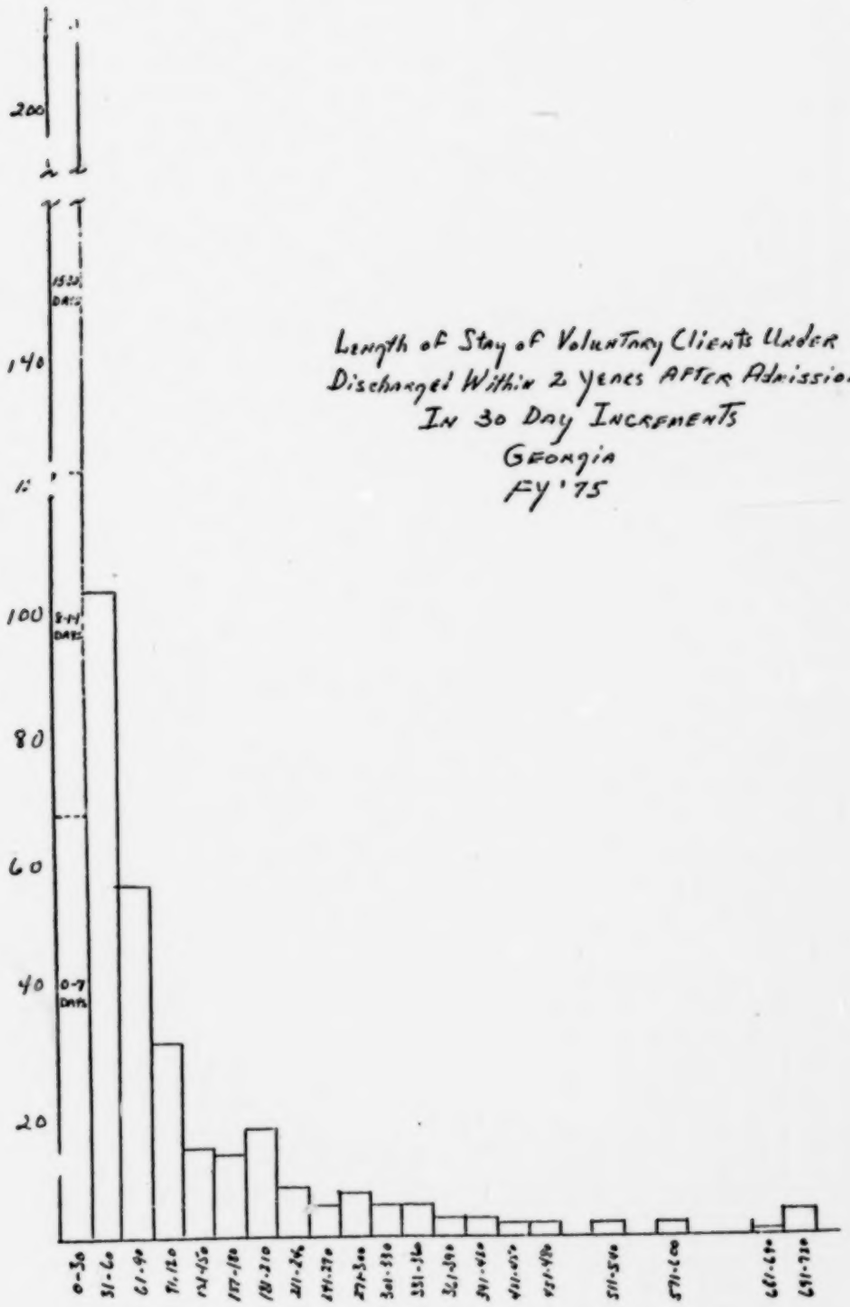


Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia
FY '69 - FY '76

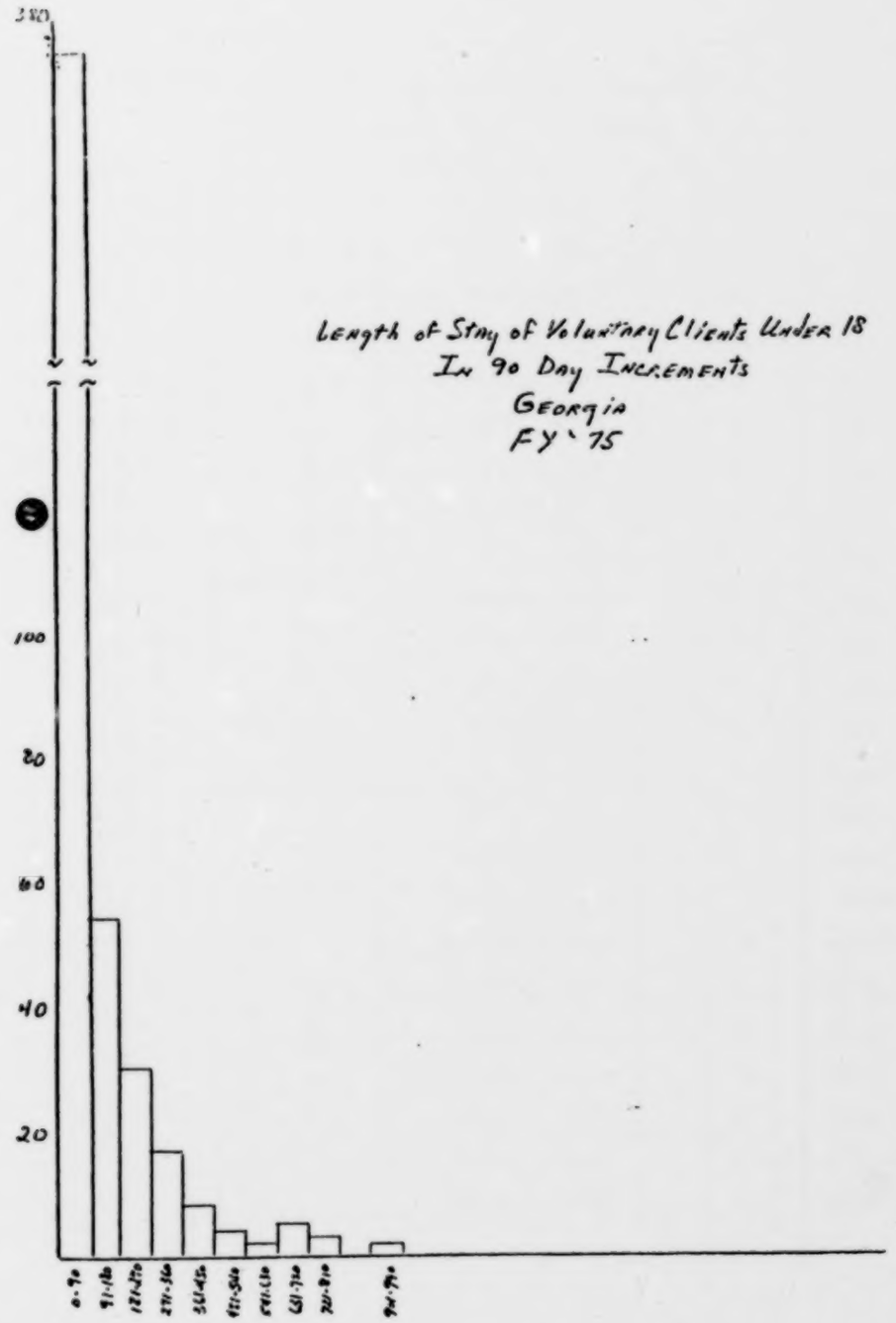


Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia
FY '69 - FY '76

Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia
FY '75



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia
FY '75



Length of Stay by Voluntarily Admitted Clients Under 18 Receiving Mental Health Services by Fiscal Year of Discharge
Under 18 - 30 Day Increments

Days	# of Clients	Days Range	# of Clients	Days Range	# of Clients
0 - 30	692	721 - 750	4	1441 - 1470	1
31 - 60	365	751 - 780	4	1471 - 1500	
61 - 90	245	781 - 810	4		
91 - 120	138	811 - 840	3	1561 - 1590	1
121 - 150	86	841 - 870		1591 - 1620	1
151 - 180	64	871 - 900	2	1621 - 1650	1
181 - 210	41	901 - 930	3	1861 - 1890	1
211 - 240	44	931 - 960	2		
241 - 270	36	961 - 990		1921 - 1950	1
271 - 300	43	991 - 1020	4	2011 - 2040	1
301 - 330	32	1021 - 1050	2	2281 - 2310	
331 - 360	26	1051 - 1080	2		
361 - 390	25	1081 - 1110			
391 - 420	14	1111 - 1140			
421 - 450	17	1141 - 1170			
451 - 480	15	1171 - 1200	1		
481 - 510	7	1201 - 1230	1		
511 - 540	5	1231 - 1260			
541 - 570	4	1261 - 1290			
571 - 600	5	1291 - 1320	3		
601 - 630	4	1321 - 1350			
631 - 660	3	1351 - 1380			
661 - 690	7	1381 - 1410			
691 - 720	6	1411 - 1440			

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving Mental Health Services by Fiscal Year of Discharge
Central State Hospital

	Days 0-7	8-14	15-30	31-60	61-90	Months* 0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	Over 2 Y.
Total	15	16	22	50	54	157	70	41	36	25	13	8	11	29
FY 69	1			2	5	8	4	3	3		2	2	1	1
FY 70	2	1	2	7	10	22	3	4	5	2	2	1		1
FY 71	1	2	3	2	6	14	13	7	5	3	1		1	1
FY 72	1			2	3	6	10	5	2	4	1		2	4
FY 73	3	1	3	6	2	15	9	10	6	3	1		2	3
FY 74	1	3	4	10	13	31	11	7	6	8	3	2	1	12
FY 75	4	8	8	19	13	52	15	5	7	2	3	2	3	7
FY 76	2	1	2	2	2	9	5		2	3		1	1	

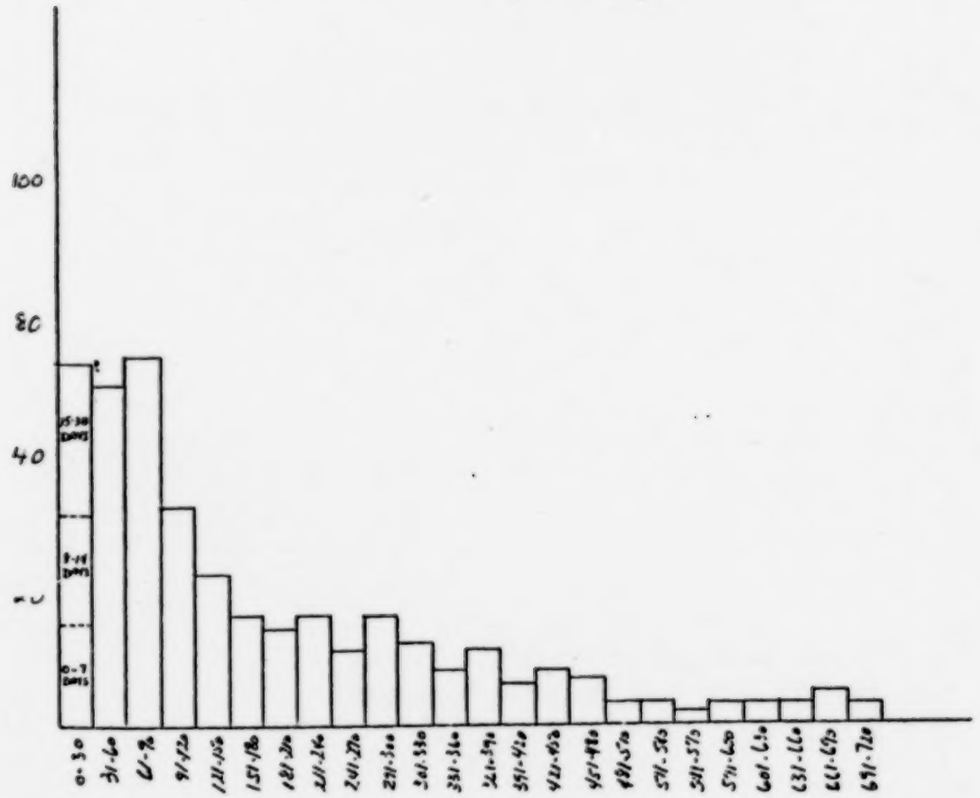
*Months are computed on basis of 30 days per month

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

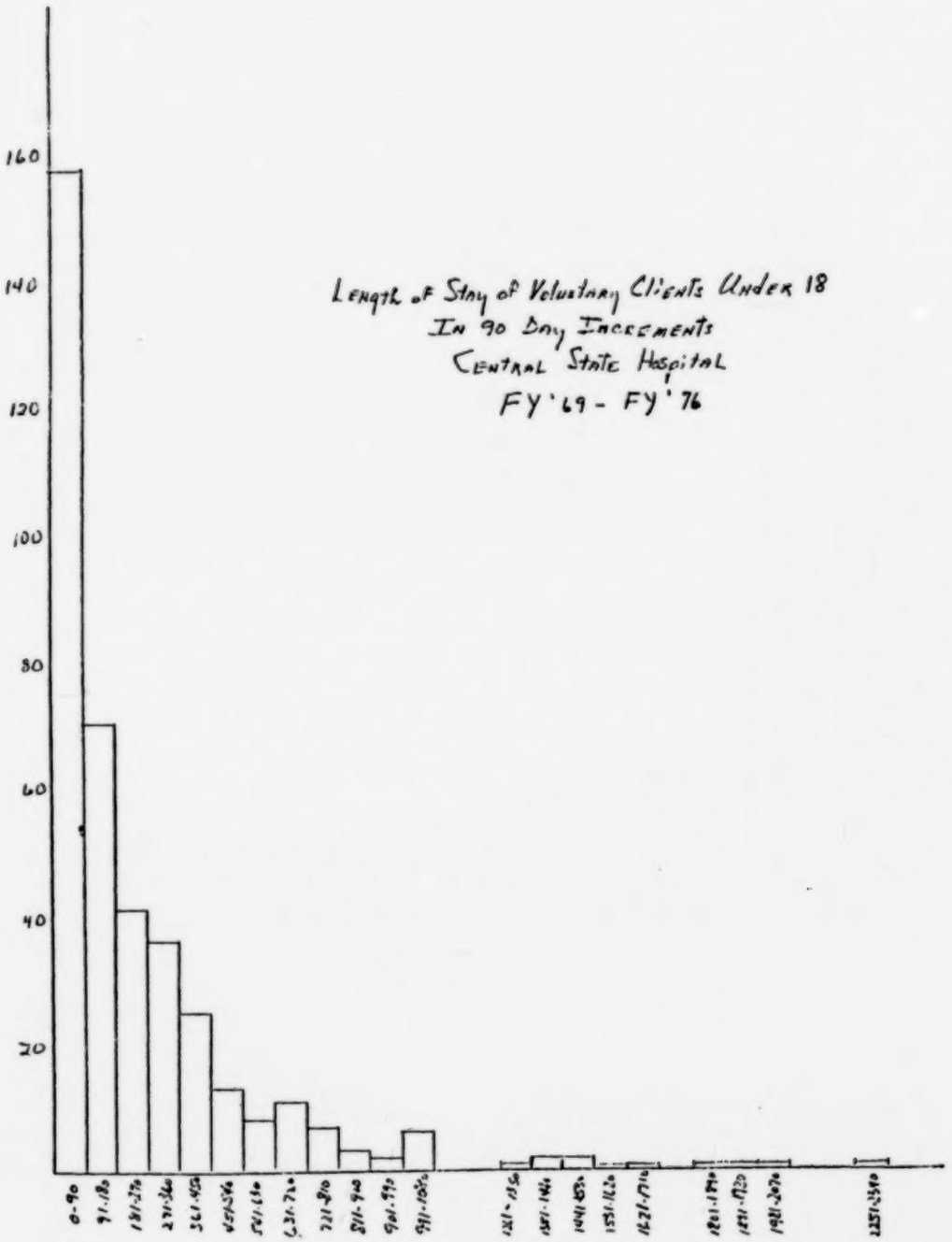
Central State Hospital

	Voluntary		Involuntary	
	Number	%	Number	%
Total	390	50%	386	50%
FY 69	47	34%	93	66%
FY 70	50	53%	44	47%
FY 71	50	69%	22	31%
FY 72	46	55%	37	45%
FY 73	54	67%	27	33%
FY 74	66	49%	70	51%
FY 75	68	44%	86	56%
FY 76	9	56%	7	44%

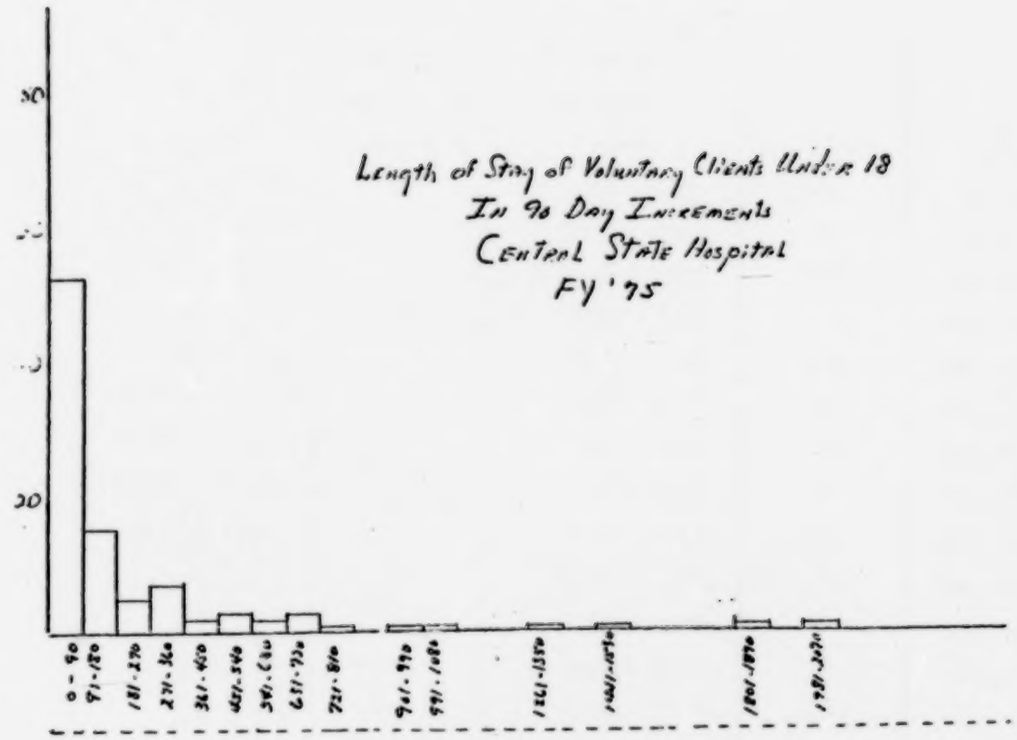
Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Central State Hospital
FY '69 - FY '76



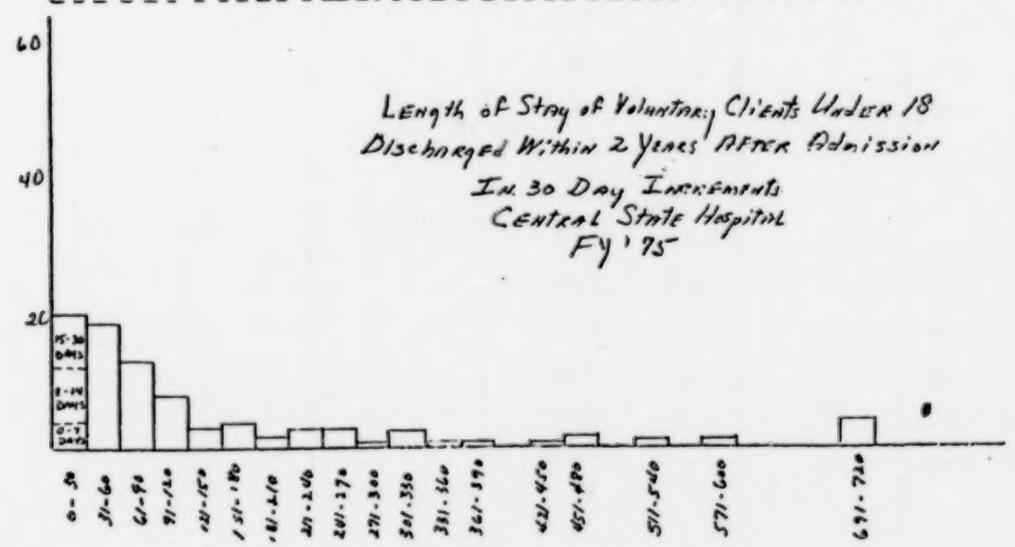
Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Central State Hospital
FY '69 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Central State Hospital
FY '75



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Central State Hospital
FY '75



Length of Stay of Voluntary Clients
Under 18 - 30 Day Intervals
Central State Hospital

Days	# of Clients	Days	# of Clients	Days	# of Clients
0 - 30	53	721 - 750	4	1441 - 1470	1
31 - 60	50	751 - 780	2	1471 - 1500	2
61 - 90	54	781 - 810	1	1561 - 1590	1
91 - 120	32	811 - 840	2	1591 - 1620	1
121 - 150	22	841 - 870		1651 - 1680	1
151 - 180	16	871 - 900	1	1861 - 1890	1
181 - 210	14	901 - 930	1	1921 - 1950	1
211 - 240	16	931 - 960	1	2011 - 2040	1
241 - 270	11	961 - 990		2281 - 2310	1
271 - 300	16	991 - 1020	3		
301 - 330	12	1021 - 1050	1		
331 - 360	8	1051 - 1080	2		
361 - 390	11	1081 - 1110			
391 - 420	6	1111 - 1140			
421 - 450	8	1141 - 1170			
451 - 480	7	1171 - 1200			
481 - 510	3	1201 - 1230			
511 - 540	3	1231 - 1260			
541 - 570	2	1261 - 1290			
571 - 600	3	1291 - 1320	3		
601 - 630	3	1321 - 1350			
631 - 660	3	1351 - 1380			
661 - 690	5	1381 - 1410	1		
691 - 720	3	1411 - 1440	1		

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Southwestern State Hospital

	Days					Months*								
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	Over 2 Yrs
Total	10	20	14	10	3	57	6	2	2	2	1		1	1
FY 69														
FY 70														
FY 71														
FY 72			1	4		5	1							
FY 73	6	5	2		2	15	1		1	1	1			
FY 74	1	8	2	1		12	2			1				
FY 75	3	4	5	3		15		2					1	1
FY 76		3	4	2	1	10	2		1					

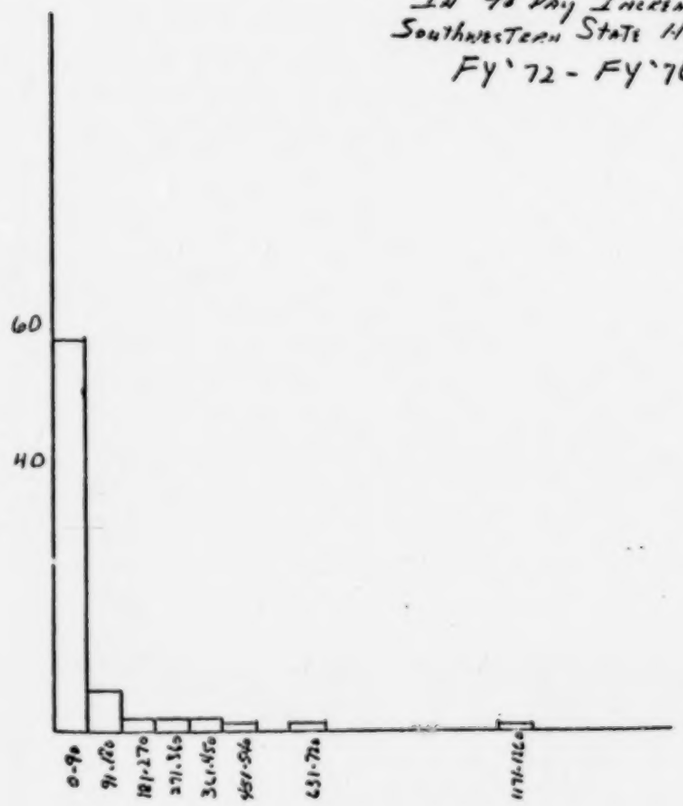
* Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

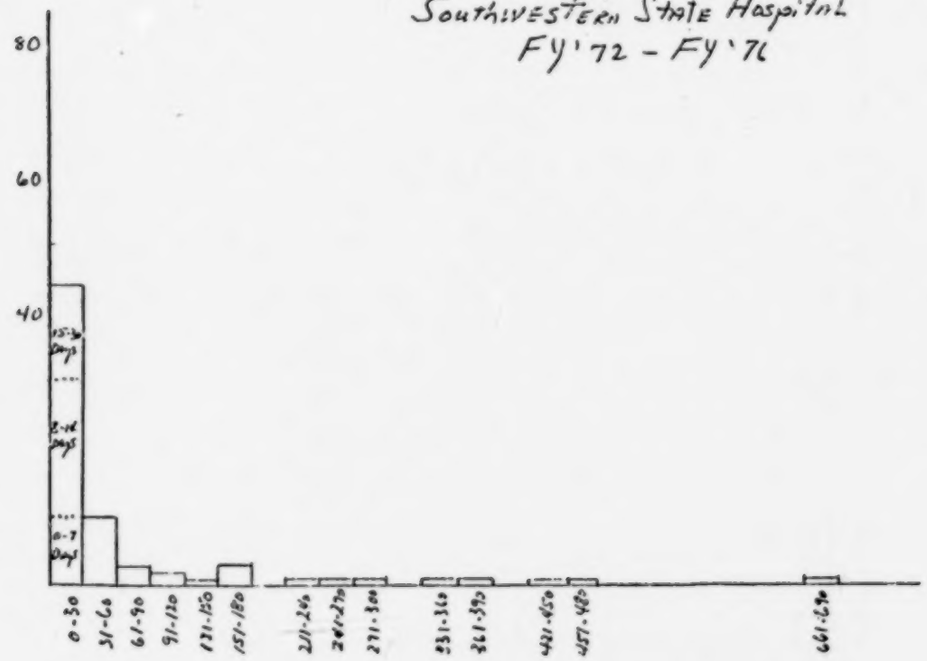
Southwestern State Hospital

	Voluntary		Involuntary	
	Number	%	Number	%
Total	79	65%	43	35%
FY 69				
FY 70				
FY 71				
FY 72	10	42%	14	58%
FY 73	24	80%	6	20%
FY 74	12	57%	9	43%
FY 75	13	68%	6	32%
FY 76	20	71%	8	29%

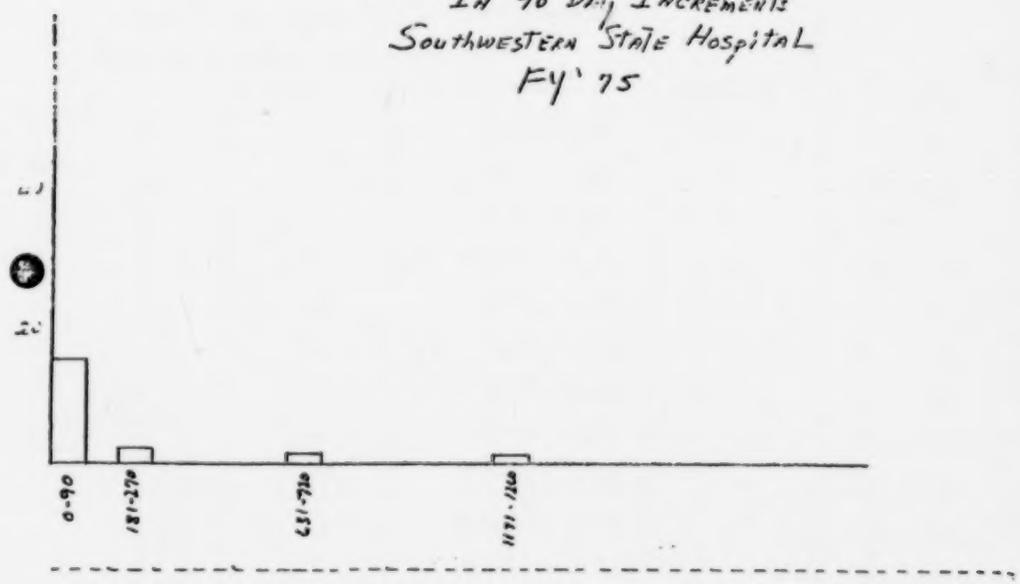
Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Southwestern State Hospital
FY '72 - FY '76

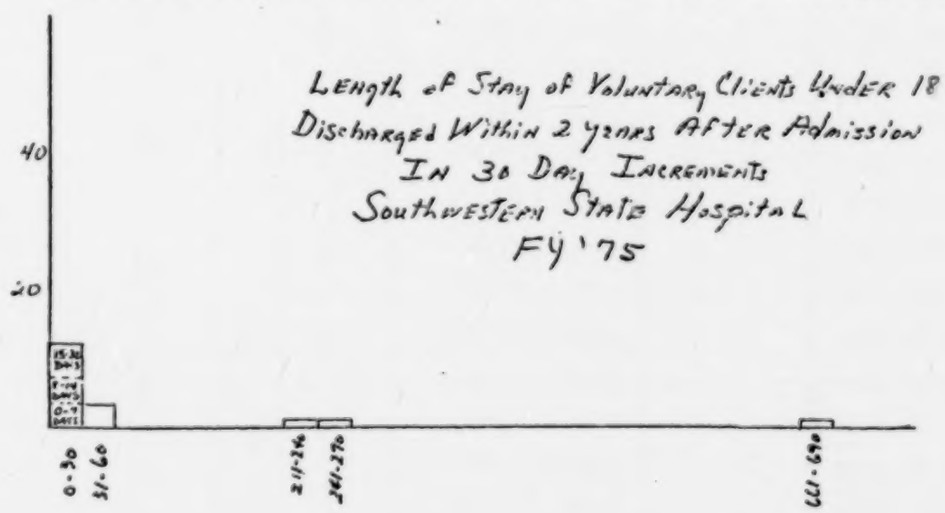


Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Southwestern State Hospital
FY '72 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Southwestern State Hospital
FY '75





Length of Stay of Voluntary Clients Under 18
Discharged Within 2 years After Admission
In 30 Day Increments
Southwestern State Hospital
FY '75

Length of Stay of Voluntary Clients
Under 18 - 30 Day Interval
Southwestern State Hospital

Days	# of Clients	Days	# of Clients		
0 - 30	44	721 - 750		1441 - 1470	
31 - 60	10	751 - 780		1471 - 1500	
61 - 90	3	781 - 810			
91 - 120	2	811 - 840			
121 - 150	1	841 - 870			
151 - 0	3	871 - 900			
181 - 210		901 - 930			
211 - 240	1	931 - 960			
241 - 270	1	961 - 990			
271 - 300	1	991 - 1020			
301 - 330		1021 - 1050			
331 - 360	1	1051 - 1080			
361 - 390	1	1081 - 1110			
391 - 420		1111 - 1140			
421 - 450	1	1141 - 1170			
451 - 480	1	1171 - 1200	1		
481 - 510		1201 - 1230			
511 - 540		1231 - 1260			
541 - 570		1261 - 1290			
571 - 600		1291 - 1320			
31 - 630		1321 - 1350			
631 - 660		1351 - 1380			
661 - 690	1	1381 - 1410			
691 - 720		1411 - 1440			

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Ga. Mental Health Institute

	Days				Months*								
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	Over 2 Yrs
Total	29	18	38	39	11	165	83	39	14	14	7	1		3
FY 69														
FY 70							7	3						
FY 71	1	1	4	1	5	12	25	11	3	2				1
FY 72		2	4	10	8	24	24	8	4	5	1			1
FY 73	4	1	2	10	8	25	19	6	4	4	6	1		
FY 74	14	7	7	8	12	48	9	11	3	3				1
FY 75	10	7	21	10	8	56								
FY 76														

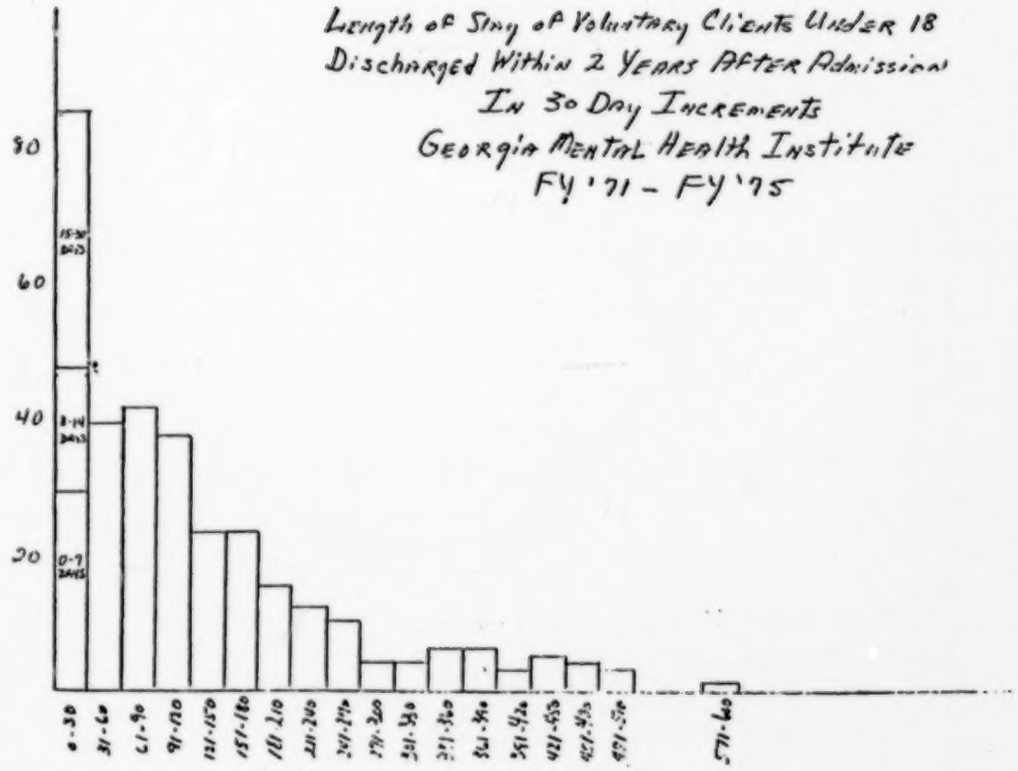
*Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

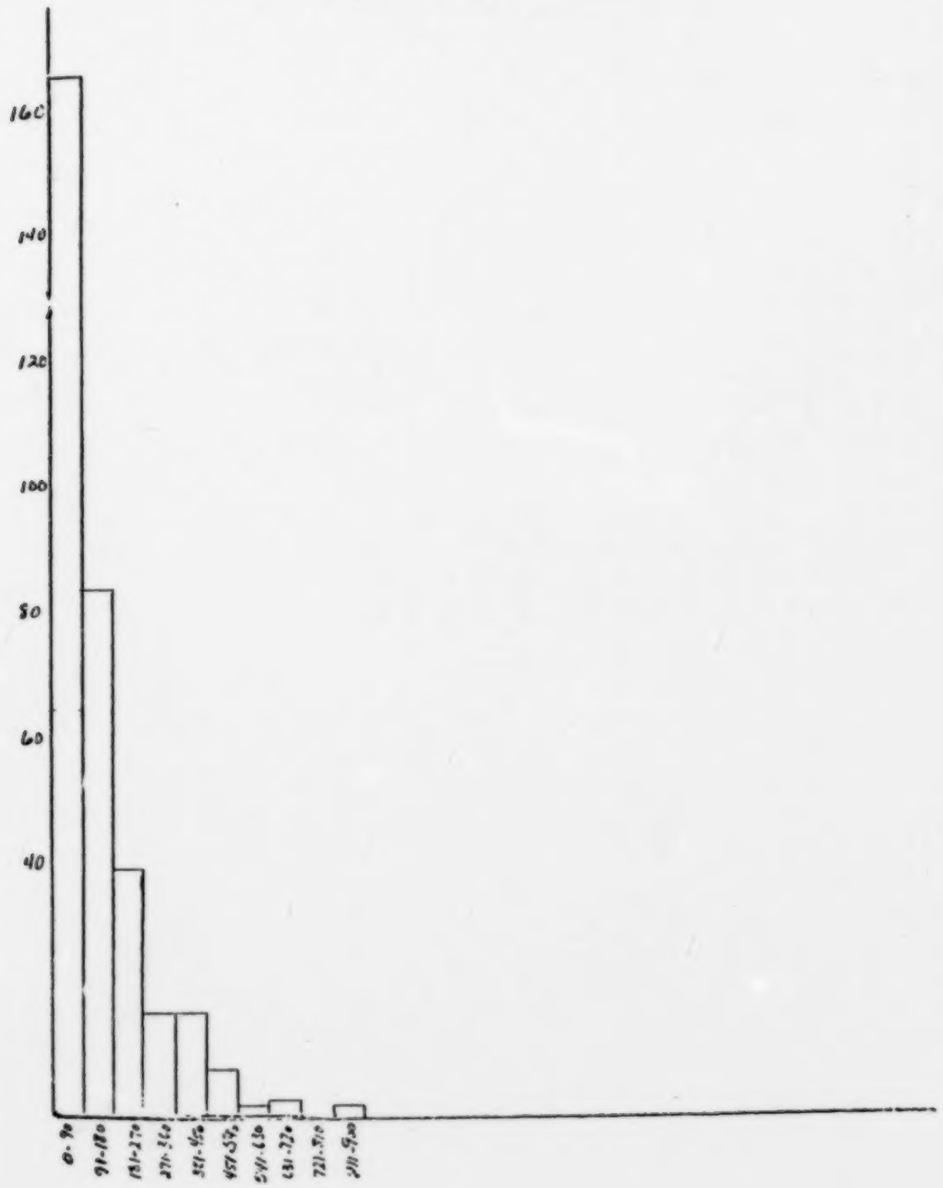
Ga. Mental Health Institute

	Voluntary		Involuntary	
	Number	%	Number	%
Total	326	96%	15	4%
FY 69				
FY 70	1	100%		
FY 71	40	100%		
FY 72	70	100%		
FY 73	72	100%		
FY 74	81	94%	5	6%
FY 75	62	86%	10	14%
FY 76				

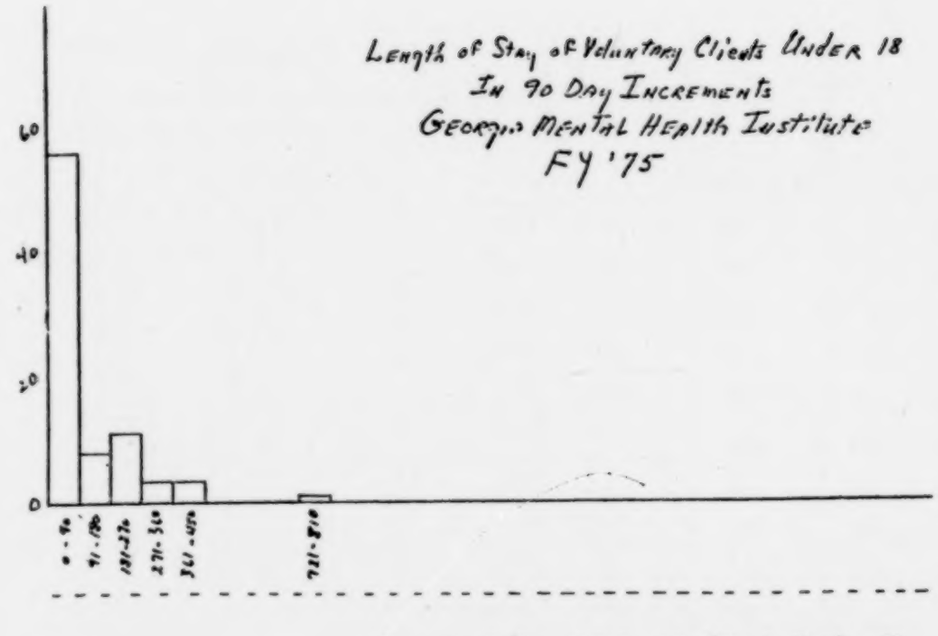
Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Mental Health Institute
FY '71 - FY '75



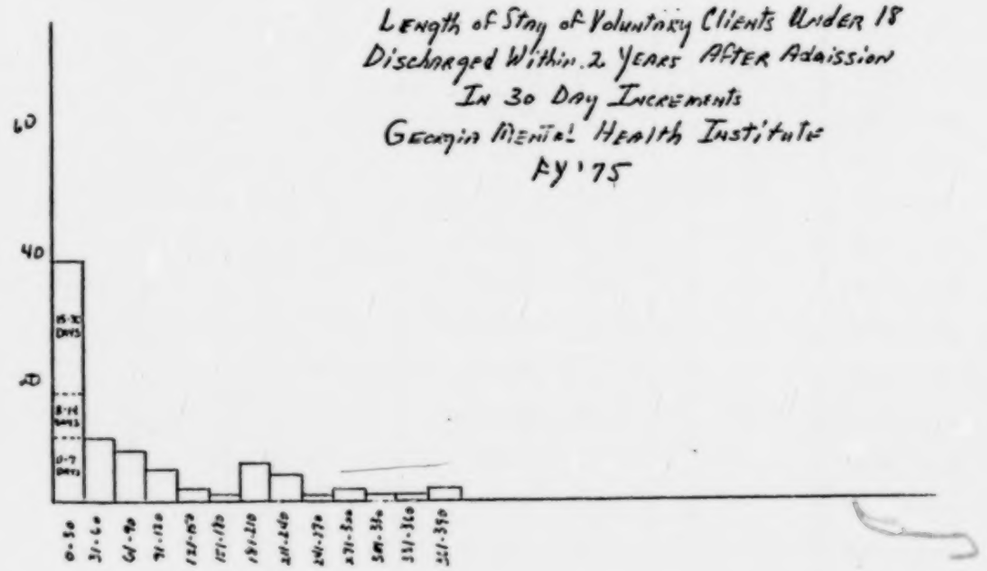
Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Mental Health Institute
FY '71 – FY '75



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Mental Health Institute
FY '75



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Mental Health Institute
FY '75



Length of Stay of Voluntary Clients
Under 18: 30 Day Extract
Georgia Mental Health Institute

Days	# of Clients	Days	# of Clients	Days	# of Clients
0 - 30	85	721 - 750		1441 - 1470	
31 - 60	39	751 - 780		1471 - 1500	
61 - 90	41	781 - 810	1		
91 - 120	37	811 - 840			
121 - 150	23	841 - 870			
151 - 180	23	871 - 900			
181 - 210	15	901 - 930			
211 - 240	12	931 - 960	1		
241 - 270	10	961 - 990			
271 - 300	4	991 - 1020			
301 - 330	4	1021 - 1050			
331 - 360	6	1051 - 1080			
361 - 390	6	1081 - 1110			
391 - 420	3	1111 - 1140			
421 - 450	5	1141 - 1170			
451 - 480	4	1171 - 1200			
481 - 510		1201 - 1230			
511 - 540	3	1231 - 1260			
541 - 570		1261 - 1290			
571 - 600	1	1291 - 1320			
601 - 630		1321 - 1350			
631 - 660		1351 - 1380			
661 - 690		1381 - 1410			
691 - 720		1411 - 1440			

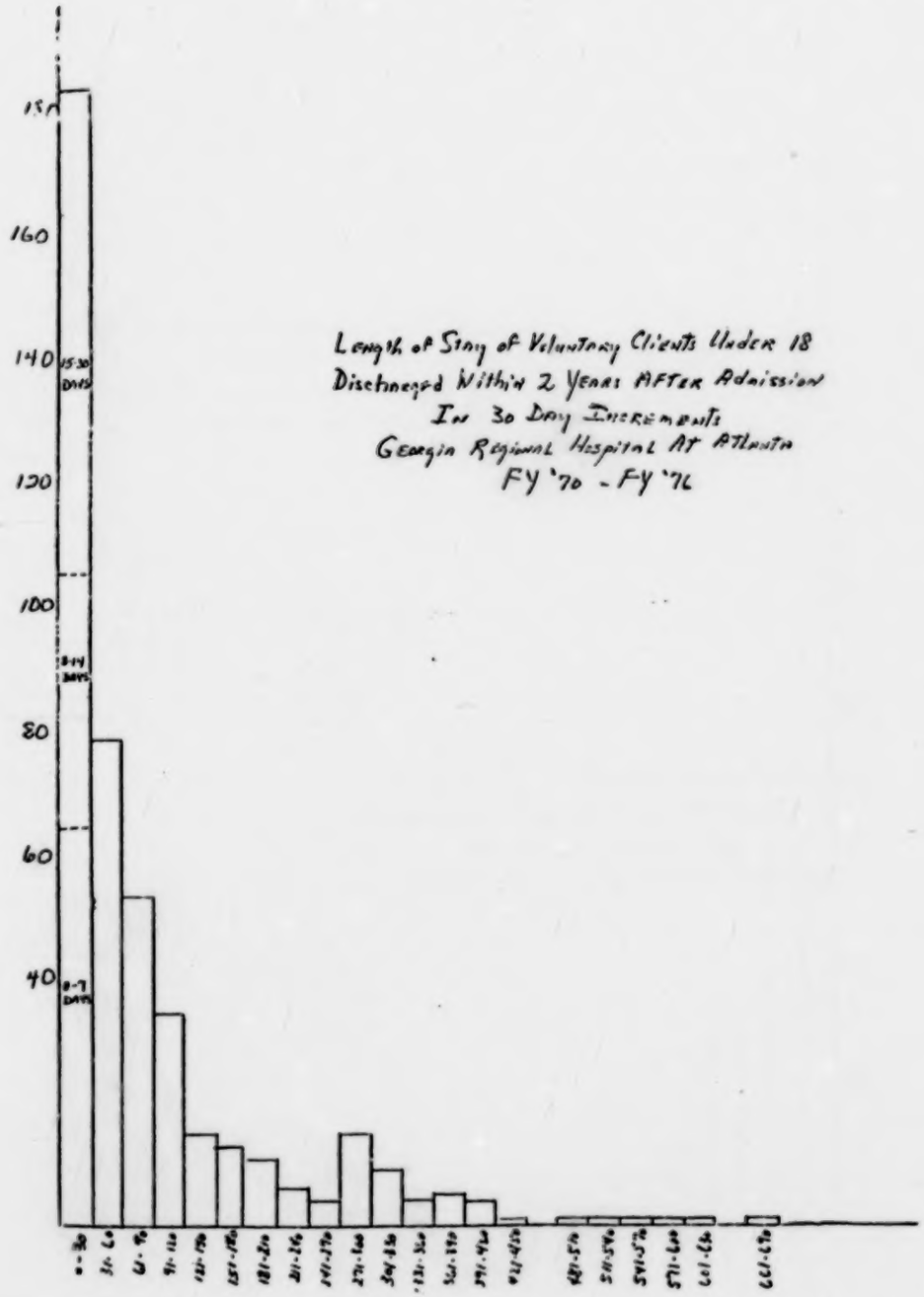
Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Ga. Regional Hospital at Atlanta

	Days					Months*								Over
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	2 Yr.
Total	64	41	78	78	53	314	62	21	28	10	5	3	4	14
FY 69														
FY 70		1		5	2	8	4	1						
FY 71	2		5	8	3	18	7	2	1	1				1
FY 72	4	2	3	4	10	23	5	5	4	3	1	2	1	4
FY 73	4	7	14	9	7	41	12	1	9	2	1		1	1
FY 74	25	13	28	22	16	104	12	1	5	1	3		1	5
FY 75	25	14	22	22	14	97	16	9	6	2			1	3
FY 76	4	4	6	8	1	23	6	2	3	1		1		

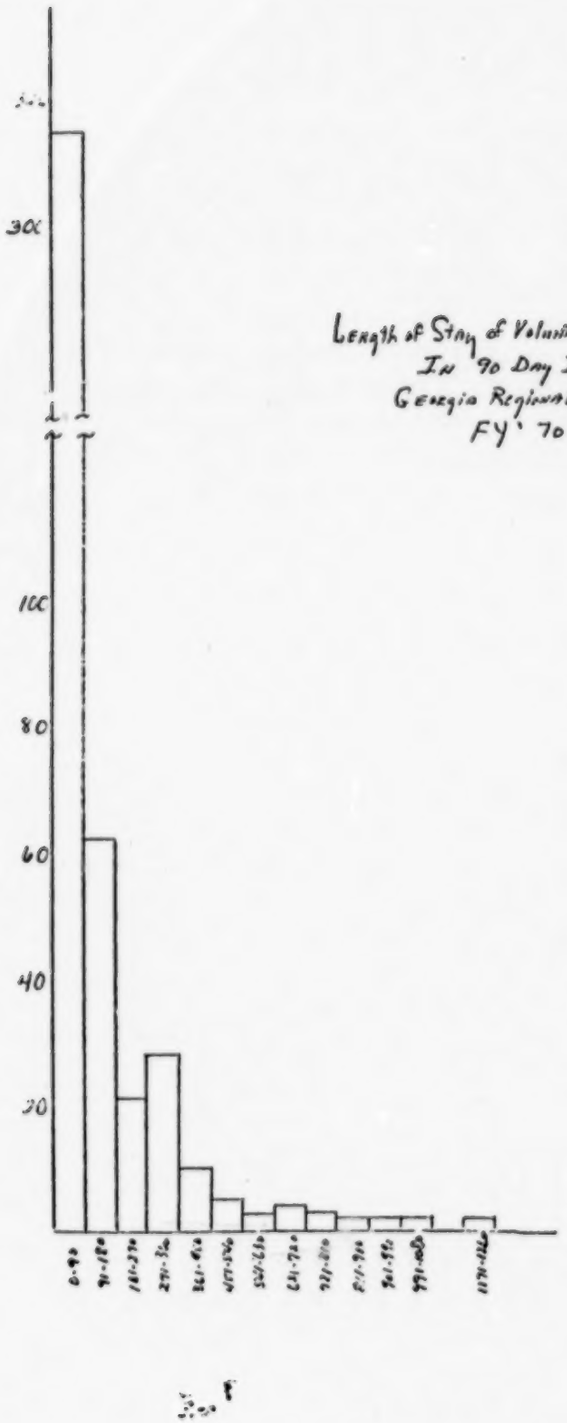
*Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission
GEORGIA REGIONAL HOSPITAL AT ATLANTA

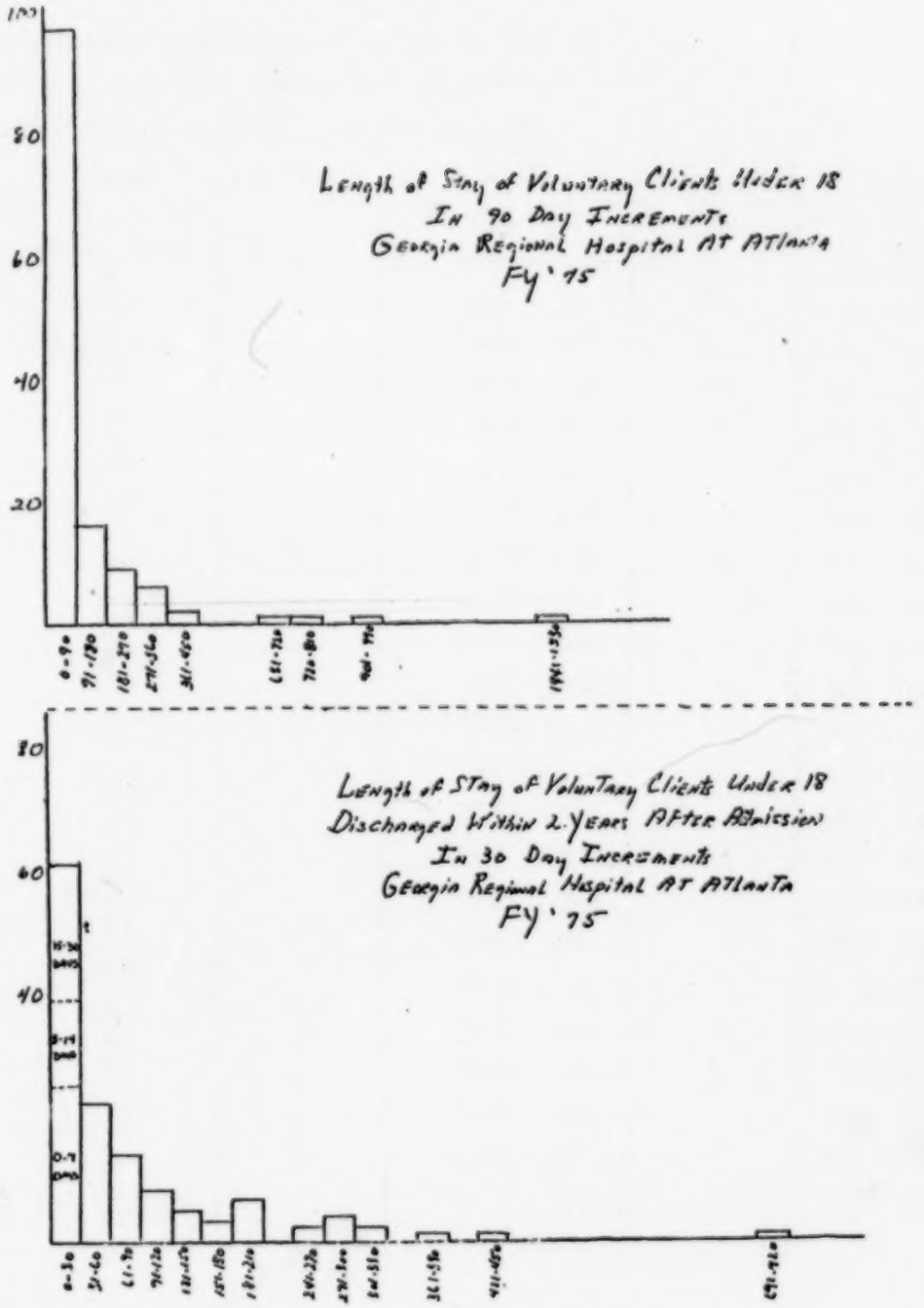
	Voluntary Number	%	Involuntary Number	%
Total	474	74%	168	26%
FY 69	3	75%	1	25%
FY 70	33	94%	2	6%
FY 71	41	87%	6	13%
FY 72	45	74%	16	26%
FY 73	76	74%	26	26%
FY 74	126	68%	60	32%
FY 75	134	75%	45	25%
FY 76	16	57%	12	43%



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital At Atlanta
FY '70 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Regional Hospital AT Atlanta
FY '70 - FY '76



Length of Stay by Voluntary Clients
Under 18 - 30 Day Sections
Georgia Regional Hospital at Atlanta

Days	# of Clients	Days	# of Clients	Days	# of Clients
0 - 30	193	721 - 750	2	1441 - 1470	1
31 - 60	78	751 - 780	1	1471 - 1500	
61 - 90	53	781 - 810	1		
91 - 120	34	811 - 840		1561 - 1590	1
121 - 150	15	841 - 870			
151 - 180	13	871 - 900	1		
181 - 210	11	901 - 930	2		
211 - 240	6	931 - 960			
241 - 270	4	961 - 990			
271 - 300	15	991 - 1020	1		
301 - 330	9	1021 - 1050	1		
331 - 360	4	1051 - 1080			
361 - 390	5	1081 - 1110			
391 - 420	4	1111 - 1140			
421 - 450	1	1141 - 1170			
451 - 480	3	1171 - 1200			
481 - 510	1	1201 - 1230			
511 - 540	1	1231 - 1260			
541 - 570	1	1261 - 1290			
571 - 600	1	1291 - 1320	2		
601 - 630	1	1321 - 1350			
631 - 660		1351 - 1380			
661 - 690	1	1381 - 1410			
691 - 720	3	1411 - 1440			

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Ga. Regional Hospital at Augusta

	Days					Months *								Over 2 Yrs
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	
Total	51	46	77	72	48	294	22	13	5		1	1		
FY 69														
FY 70														
FY 71														
FY 72														
FY 73	5	8	10	11	10	44	7	5				1		
FY 74	20	11	28	24	20	103	7	3	5					
FY 75	18	20	28	25	15	106	7	3			1			
FY 76	8	7	11	12	3	41	1							

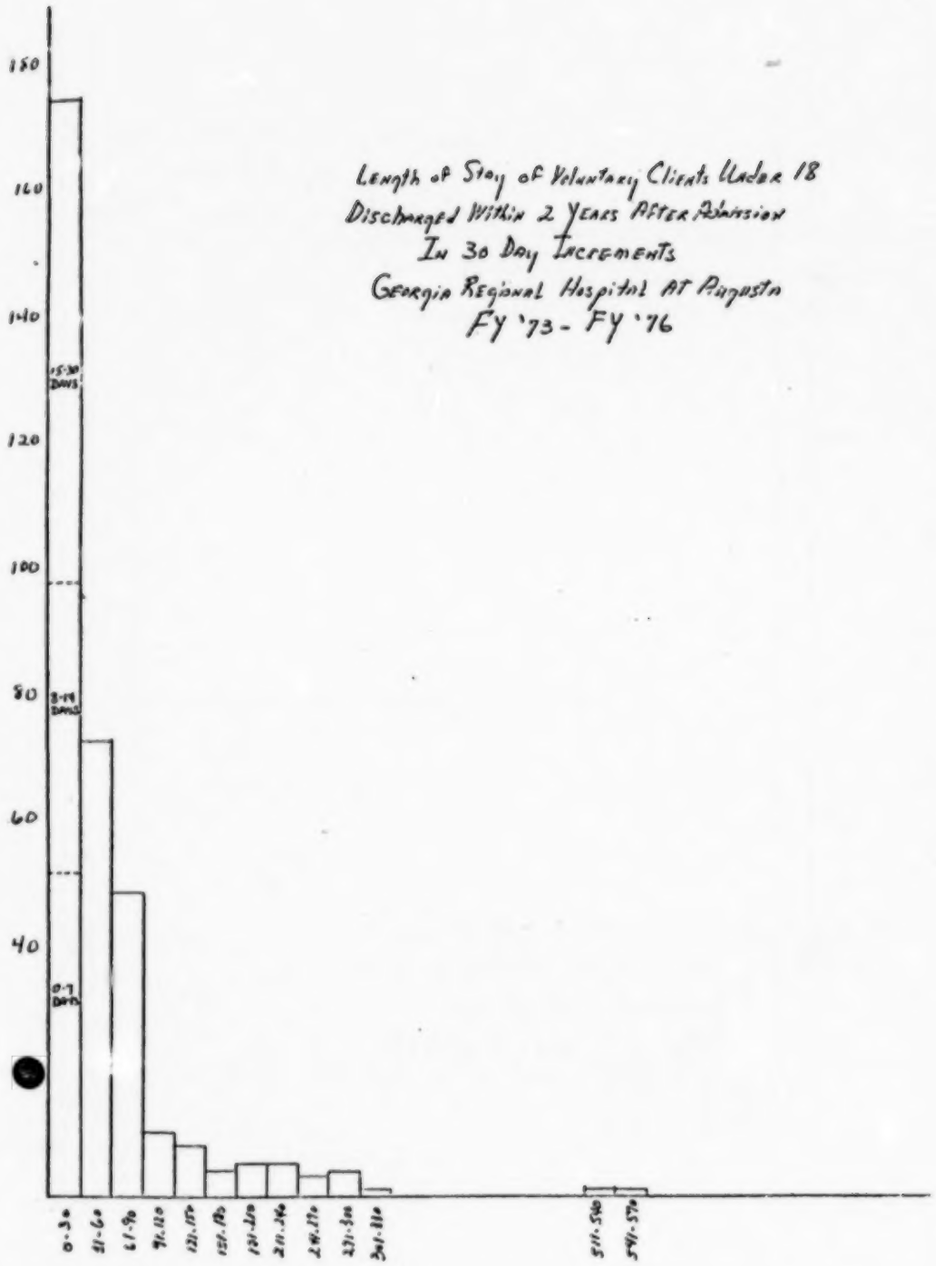
* Months are computed on basis of 30 days per month.

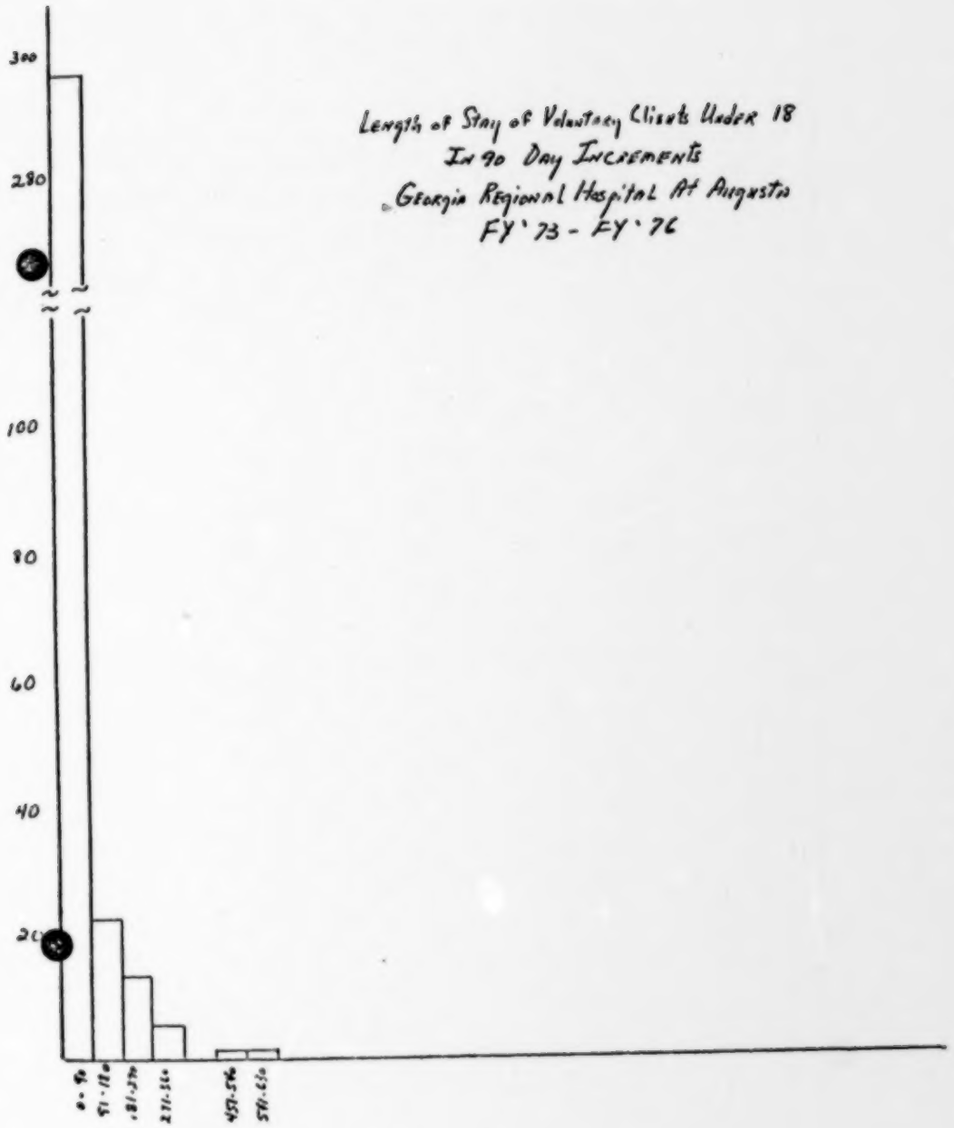
Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

Ga. Regional Hospital at Augusta

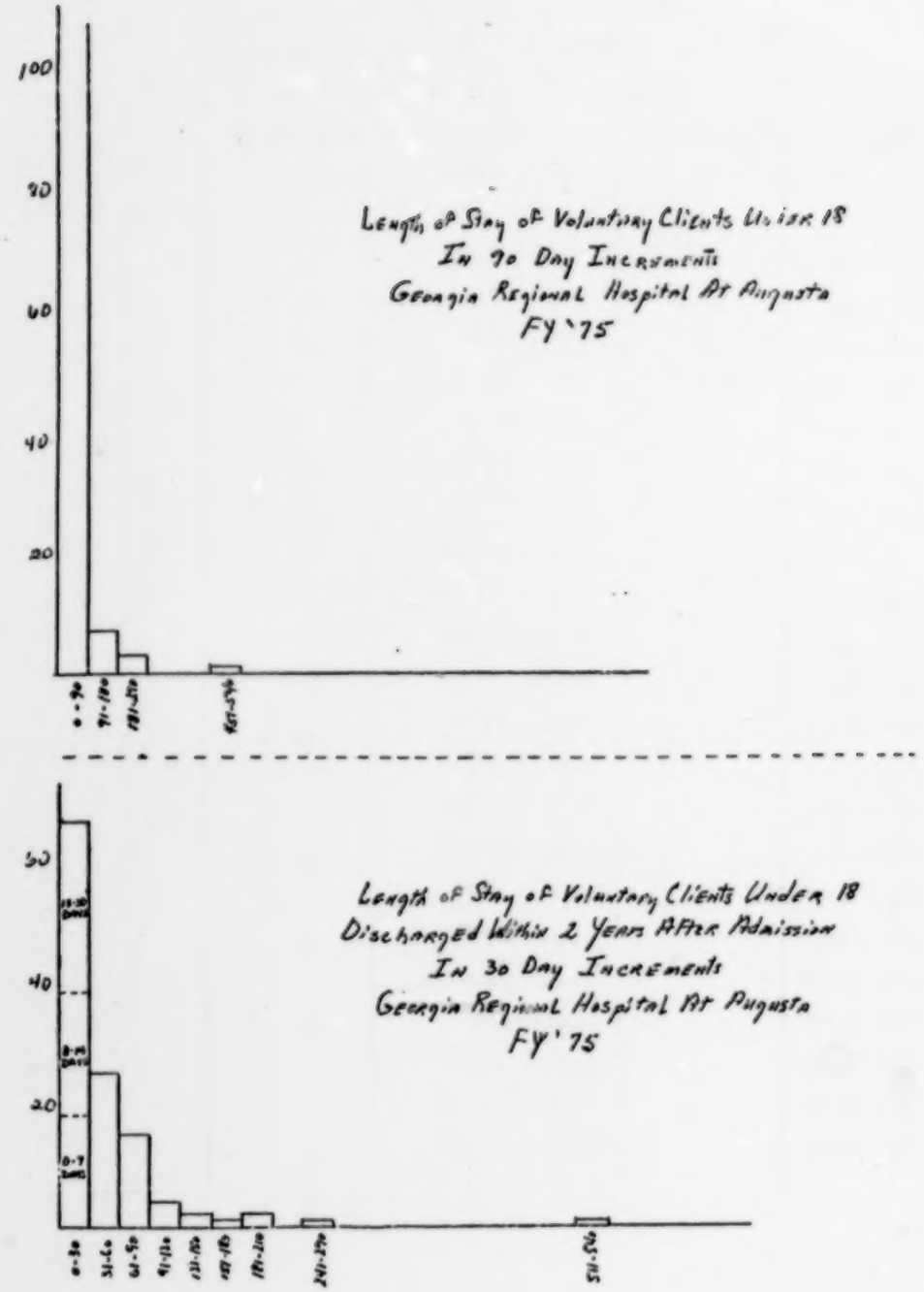
	Voluntary		Involuntary	
	Number	%	Number	%
Total	336	57%	252	43%
FY 69				
FY 70				
FY 71				
FY 72	5	83%	1	17%
FY 73	84	60%	56	40%
FY 74	108	55%	88	45%
FY 75	107	55%	88	45%
FY 76	32	63%	19	37%

Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital at Augusta
FY '73 - FY '76





Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Regional Hospital At Augusta
FY '73 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Regional Hospital At Augusta
FY '75

Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital At Augusta
FY '75

Length of Stay of Voluntary Children Under 18 - 30 Day Sections Georgia Regional Hospital at Augusta

Days	# of Children	Days	# of Children		
0 - 30	174	721 - 750		1441 - 1470	
31 - 60	72	751 - 780		1471 - 1500	
61 - 90	48	781 - 810			
91 - 120	10	811 - 840			
121 - 150	8	841 - 870			
151 - 180	4	871 - 900			
181 - 210	5	901 - 930			
211 - 240	5	931 - 960			
241 - 270	3	961 - 990			
271 - 300	4	991 - 1020			
301 - 330	1	1021 - 1050			
331 - 360		1051 - 1080			
361 - 390		1081 - 1110			
391 - 420		1111 - 1140			
421 - 450		1141 - 1170			
451 - 480		1171 - 1200			
481 - 510		1201 - 1230			
511 - 540	1	1231 - 1260			
541 - 570	1	1261 - 1290			
571 - 600		1291 - 1320			
601 - 630		1321 - 1350			
631 - 660		1351 - 1380			
661 - 690		1381 - 1410			
691 - 720		1411 - 1440			

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving Mental Health Services by Fiscal Year of Discharge
GEORGIA REGIONAL AT SAVANNAH

	Days 0-7	8-14	15-30	31-60	61-90	Months 0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24
Total	24	36	85	114	45	307	47	32	16	5			
FY 69													
FY 70													
FY 71							12	5					
FY 72	2	8	14	15	14	53	19	22	12	3			
FY 73	4	12	32	28	10	86	7	5	2	1			
FY 74	16	12	28	43	12	111	9		1	1			
FY 75	4	4	7	23	6	44	1		1				
FY 76	1		4	5	3	13							

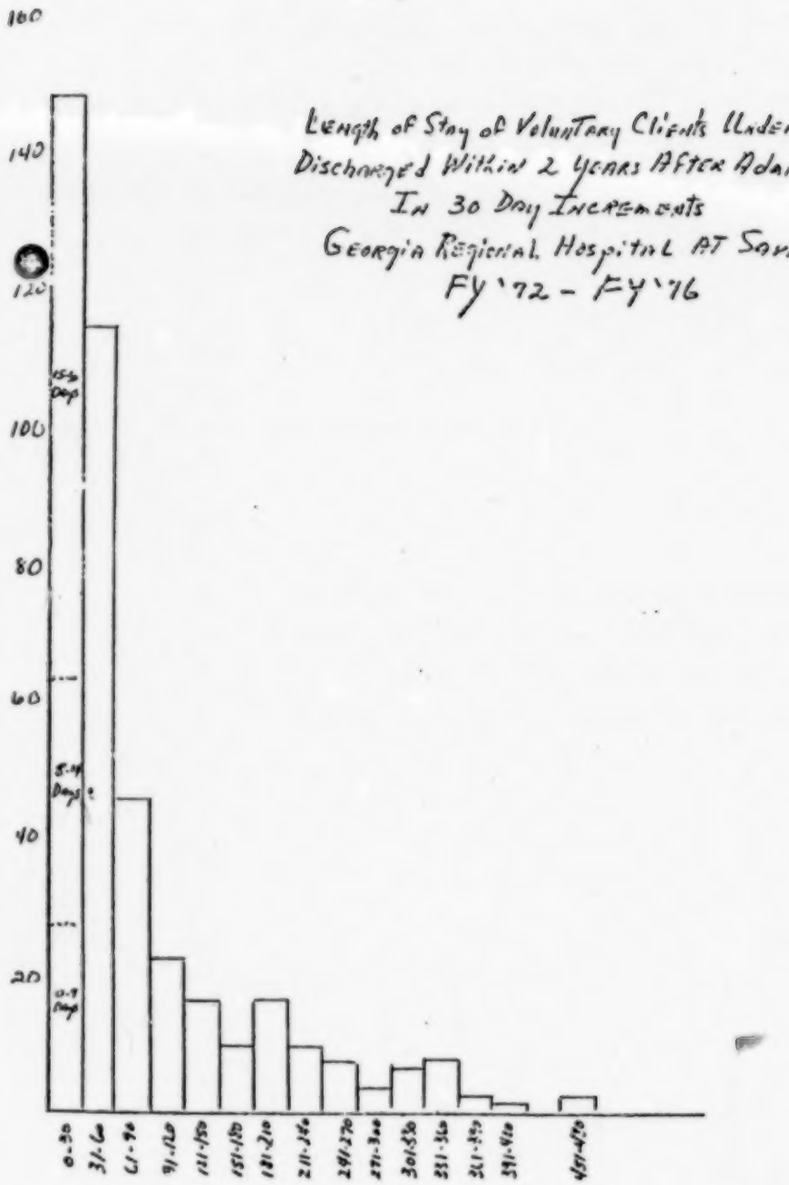
* Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

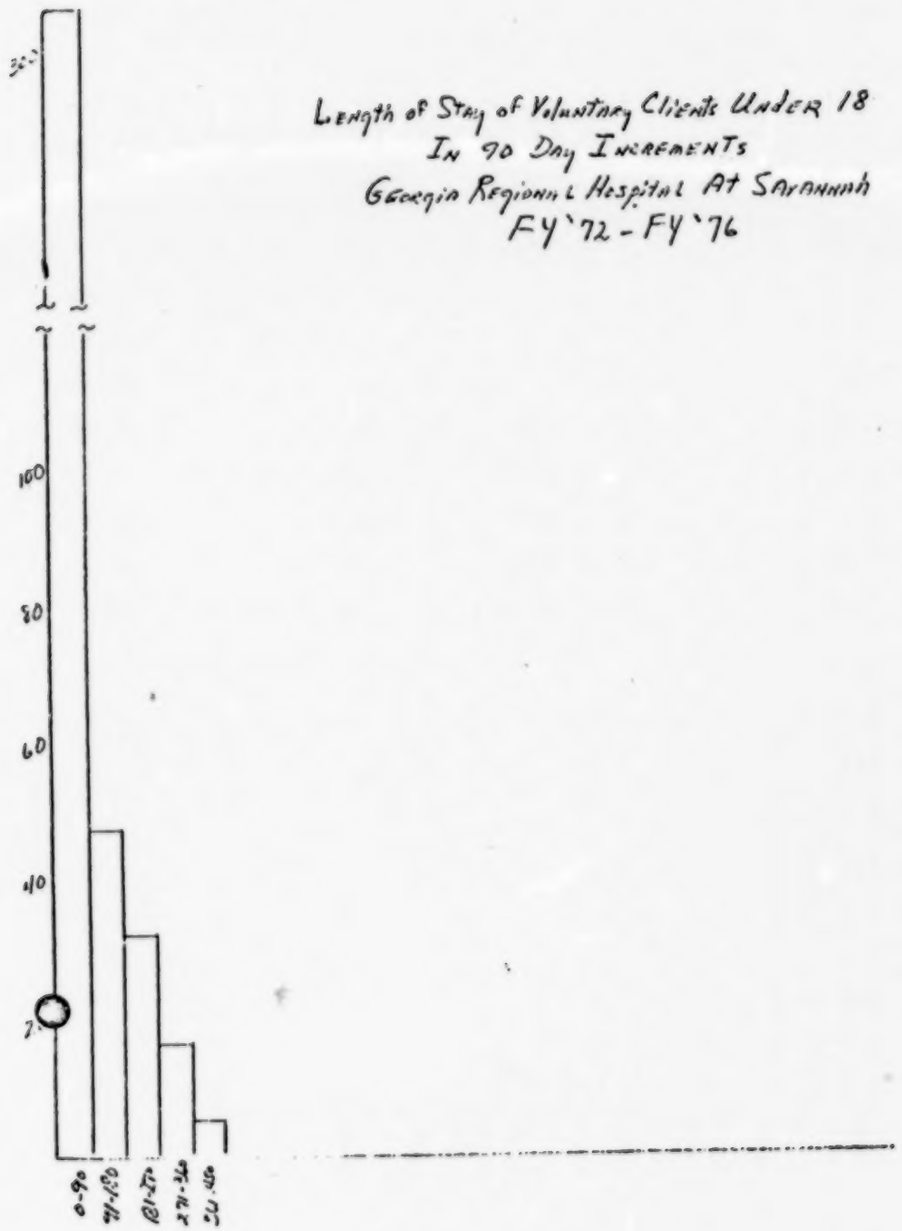
Ga. Regional Hospital at Savannah

	Voluntary Number	%	Involuntary Number	%
Total	407	66%	241	34%
FY 69				
FY 70				
FY 71				
FY 72	70	78%	20	22%
FY 73	148	69%	66	31%
FY 74	122	65%	65	35%
FY 75	54	41%	76	59%
FY 76	13	48%	14	52%

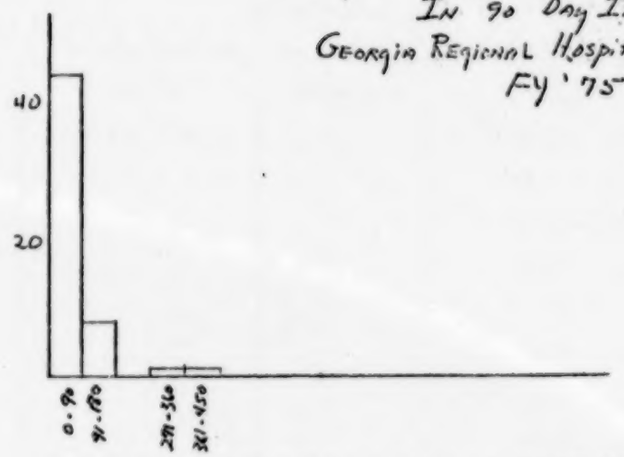
Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital AT Savannah
FY '72 - FY '76



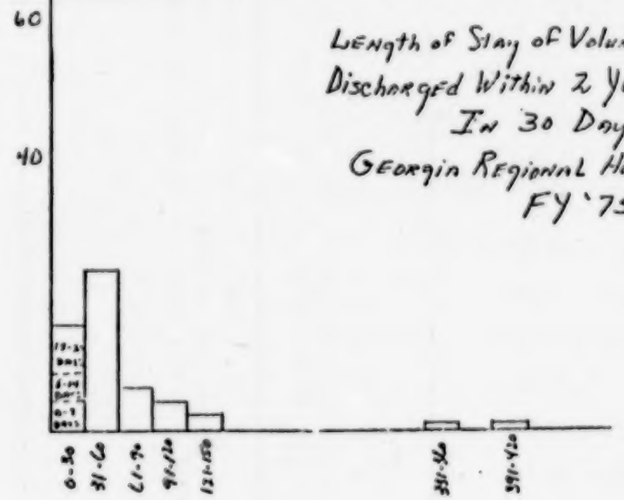
Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Regional Hospital At Savannah
FY '72 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Regional Hospital At Savannah
FY '75



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital At Savannah
FY '75



Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Georgia Regional Hospital at Savannah

Days	# of Clients	Range	# of Days	Range
0 - 30	148	721 - 750	1441 - 1470	
31 - 60	114	751 - 780	1471 - 1500	
61 - 90	43	781 - 810		
91 - 120	22	811 - 840		
121 - 150	16	841 - 870		
151 - 180	9	871 - 900		
181 - 210	16	901 - 930		
211 - 240	9	931 - 960		
241 - 270	7	961 - 990		
271 - 300	3	991 - 1020		
301 - 330	6	1021 - 1050		
331 - 360	7	1051 - 1080		
361 - 390	2	1081 - 1110		
391 - 420	1	1111 - 1140		
421 - 450	2	1141 - 1170		
451 - 480		1171 - 1200		
481 - 510		1201 - 1230		
511 - 540		1231 - 1260		
541 - 570		1261 - 1290		
571 - 600		1291 - 1320		
601 - 630		1321 - 1350		
631 - 660		1351 - 1380		
661 - 690		1381 - 1410		
691 - 720		1411 - 1440		

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
West Central Ga. Regional Hospital

	Days					Months*								Over 2 Yrs
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	
Total	1	1	3	2	1	8	3							
FY 69														
FY 70														
FY 71														
FY 72														
FY 73														
FY 74														
FY 75	1		1	1		3								
FY 76		1	2	1	1	5	3							

* Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

West Central Ga. Regional Hospital

	Voluntary Number	%	Involuntary Number	%
Total	27		6	
FY 69				
FY 70				
FY 71				
FY 72				
FY 73				
FY 74				
FY 75	7	53%	6	47%
FY 76	20	100%	-	-

IN THE UNITED STATES DISTRICT COURT
MIDDLE OF DISTRICT OF GEORIGA
MACON DIVISION

J. L. and J. R., minors, individually and on behalf of all others similarly situated,

Plaintiffs,

v. CIVIL ACTION NO. 75-163-MAC

JAMES PARHAM, individually and as Commissioner of the Department of Human Resources; DOUGLAS SKELTON, individually and as Director of the Division of Mental Health; W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital,

Defendants.

AFFIDAVIT

Personally appeared before me, the undersigned officer, duly authorized to administer oaths, Cynthia Arnold, who states upon oath as follows:

1.

I am Cynthia Arnold, a secretary for the Division of Mental Health and Mental Retardation, Department of Human Resources.

2.

I make this affidavit on personal knowledge and for use by the Defendants in the above-styled civil action.

3.

The information in the attached exhibits was given to me by telephone by the personnel at the regional hospitals and typed therefrom, except that the information on minors at Central State Hospital was supplied directly by the Hospital.

Appendix C

This 16th day of December, 1975.

Cynthia Arnold

Cynthia Arnold

Sworn to and subscribed
before me this 16th day
of December, 1975.

Notary Public

Notary Public, Georgia State at Large
My Commission Expires April 23, 1979

REGIONAL Atlanta Regional Vol. Patients less than 18 years of age in Mental Hospitals (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
B. W.	10/10/57	10/26/75	Self	Schizo. Chronic Undifferentiated Type	11/20/75
B. M.	10/22/57	8/13/75	Parent	Schizo. Chronic Undifferentiated Type	2/18/76
C. D.	10/10/57	10/11/75	Self	Hysterical Personality	Outpatient status - 11/13/75 Transferred to C.S.H. 12/10/75
D. M.	11/19/57	10/27/75	Parent	Drug Abuse, Schizo. Chronic Undifferentiated Type	11/3/75
J. M.	5/7/62	10/22/75	Parent	Mild Retardation	11/17/76
J. B.	7/24/58	10/14/75	Self	Mild Mental Retardation	2/18/76
J. M.	3/16/64	4/30/75	Parent	Adjustment Reaction to Childhood	Unknown - probably never discharged.
J. B.	11/24/58	7/14/75	Parent	Schizo. Chronic Undifferentiated Type	1/3/76
K. L.	8/9/65	10/15/75	Parent	Schizo. Chronic Undifferentiated Type	12/12/75
L. D.	12/24/62	12/2/74	Parent	Childhood Schizo.	1/18/76

Mental Health Atlanta Regional Vol. Patients less than 18 years of age in Mental Hospitals (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
B.	3/24/55	5/7/74	Parent	Runaway Reaction	6/18/76
C.	6/9/57	9/8/75	Self	Schizo. Acute with Depression	11/5/75
T.	7/3/59	9/4/75	Parent	Explosive Personality	12/17/75-Daypatient Est. Dis. 1/31/76
V.	10/28/59	10/20/75	Self	Adjustment Reaction to Adolescence	1/3/76
W.	9/1/57	12/8/73	Self	Drug Abuse & Alcoholism Unspecified	12/8/75
J.	11/23/57	8/31/75	Self	Schizo. Chronic Undifferentiated Type	12/16/75 - Eval. Status
C.	9/24/58	10/27/75	Parent	Marijuana Addiction Drug Abuse, Adjustment Reaction to Adolescence	11/18/75
K.	11/26/57	9/10/75	Self	Moderate Mental Retardation	12/20/75
W.	7/28/53	7/8/75	Parent	Schizo. Paranoid Type	6/18/76
P.	4/2/67	7/19/74	Parent	Hyperkinetic Reaction to Childhood	2/18/76
B	8/31/62	6/10/74	Parent	Childhood Schizo.	6/18/76

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Mental Health Atlanta Regional Vol. Patients less than 18 years of age in Mental Hospitals (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
D.	3/16/62	7/9/74	Parent	Borderline MR	6/18/76
W.	6/7/61	9/29/75	Parent	Drug Dependency Anti-Social Personality	1/26/75 - Daypatient Est. Dis. - 1/31/76
C.	4/13/70	4/21/75	Parent	Schizo. Childhood with Autism	3/18/76
[illegible]	3/21/65	5/19/75	Parent	Childhood Schizo.	4/18/76
G.	5/2/59	8/1/75	Parent	Schizo. Chronic Undifferentiated Type	2/15/76
A.	6/5/59	8/5/75	Parent	Adol. Adjustment Reaction - Probable Learning Disability	Outpatient - 11/4/75 Est. Dis. - 2/12/76
T.	5/17/66	9/23/75	Parent	Hyperkinetic Reaction of Childhood	12/17/75
W.	3/27/61	10/31/75	Parent	Adjustment Reaction of Childhood & Hysterical Personality	11/3/75
S.	3/8/62	7/9/75	Parent	Non-psycotic Brain Syndrome w/epilepsy Mild Mental Retardation and Unsocialized Aggr. Reaction	11/7/75
T.	7/1/61	10/13/75	Parent	Schizo. Schizo-Affective Type	11/6/75

873

BEST COPY AVAILABLE

...Atlanta Regional Vol. Patients less than 18 years of age in Mental ...itals (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
. B.	12/15/67	10/14/75	Parent	Unsocialized Aggr. Reaction to Childhood	1/18/76
. .	2/1/62	10/22/75	Parent	Unsocialized Aggr. Reaction to Adol., Mild MR	1/12/76
. .	11/12/59	10/24/75	Parent	Hysterical Personality and Adjustment Reaction to Adolescence	11/24/75
. .	12/1/54	10/27/75	Parent	Hyperkinetic Reaction to Childhood	1/18/76

874

...Augusta Regional Vol. Patients less than 18 years of age in Mental ...itals (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
. .	7/2/57	10/29/75	Ft. Gordon Psychologist (Self)	Depressive Neurosis Hysperical Personality	12/8/75
.R.M.	2/25/59	6/2/75	Augusta M. H. Clinic (Mother)	Schizo. Childhood	5/15/76
..M.D.	6/26/62	12/29/75	Med. College of Georgia (Mother)	Depressive Neurosis	12/19/75
.S.T.	5/11/60	9/23/75	Comm. M.H. Outpatient Agency (Mother)	Adjustment Reac. to Adolescence	5/15/76
.B.K.	7/12/59	10/15/75	University Hospital (Mother)	Moderate MR	11/19/75
..C.D.	4/8/63	5/5/75	Richmond Cty. Health Dept. (Mother)	Adjustment Reac. of Childhood	1/15/76
.E.B.	8/29/57	10/20/75	Self	Alcoholism	12/2/75
.T.C.	6/6/59	10/8/75	Gracewood School & Hospital (Mother)	Moderate MR Adjustment Reac. of Adolescence	11/9/75
.A.P.	5/18/61	8/26/75	Not in Records	Adjustment Reac. to Adolescence	12/12/75
.F.B.	1/16/61	10/27/75	Outpatient Clinic-McDuffey Cty. (Mother)	Adjustment Reac. to Adolescence	11/10/75

875

[illegible] Augusta Regional Vol. Patients less than 18 years of age in Mental [illegible]pitals (not M.R. Units) on October 31, 1975. INPATIENTS.

[illegible]	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	11/19/67	10/6/75	Comm. M.H. Out-patient (Mother)	Adjustment Reac. to Childhood	12/12/75
[illegible]	4/5/68	9/3/75	Dr. Clarke (father)	Adjustment Reac. to Childhood	2/1/76
[illegible]	12/17/66	3/24/75	Augusta M.H. Clinic (Father)	Childhood Schizo.	5/15/76 - will be put on day patient
[illegible]	10/8/63	10/14/75	Griffin Cty. Out-patient Clinic (Father)	Adjustment Reac. to Adol.	11/21/75
[illegible]	9/1/60	10/24/75	Augusta Area MH Clinic (Mother)	Adjustment Reac. to Adolescence	11/14/75

[illegible] Savannah Regional Vol. Patients less than 18 years of age in Mental [illegible]pitals (not M.R. Units) on October 31, 1975. INPATIENTS.

[illegible]	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	10/1/61	10/21/75	Private Physician (Mother)	Drug Abuse Un-specified	11/15/75 - Discharged
[illegible]	5/29/60	10/24/75	DFCS-Darien Cty. (Guardian)	Adjustment Reaction	12/15/75 - Discharged
[illegible]	1/5/64	10/29/75	Private Psychia-trist (Mother)	Mild Mental Retar-dation	12/12/75 - Discharged
[illegible]	8/5/60	7/2/75	Gracewood School & Hospital (Mother)	Schizo. Childhood Type	Expected to be dis-charged within 30 days
[illegible]	11/9/59	2/28/74	Central State (Mother)	Schizo. Childhood Type	Discharge date un-determined
[illegible]	12/9/65	4/11/75	Private Psychia-trist (Father)	Unsocialized Agg. Reaction	11/26/75 - Discharged
[illegible]	3/10/60	8/13/75	Private Physician (Mother)	Acute Schizo. Episode	11/26/75 - Discharged
[illegible]	11/11/61	5/7/75	DFCS - Bulloch Cty. (Guardian)	Unsocialized Agg. Reaction	Discharge date un-determined
[illegible]	7/5/60	8/24/75	Family (Mother)	Schizo. Unspecified Type	Expected to be dis-charged within 30 days
[illegible]	6/2/59	7/7/75	Bryan Cty. M. H. Clinic (Mother)	Borderline MR	Expected to be dis-charged within 30 days
[illegible]	9/16/59	9/2/75	Liberty Cty. Court of Ordinary (Mother)	Schizo. Childhood Type	11/21/75 - Discharged
[illegible]	10/7/61	10/6/75	Ft. Stewart Out-pa[illegible]nt Clinic ([illegible]er)	Adjustment Reaction	Discharge exp[illegible]ed within 30 days

HOSPITAL Southern Regional Vol. Patients less than 18 years of age in Mental Hospitals (Incl M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
C. A.	9/26/60	10/21/75	DFCS-Wayne Cty. (Mother)	Unsocialized Agg. Reaction	11/21/75
[illegible] B.	10/1/61	10/21/75	Private Physician (Mother)	Acute Schizo. Episode	Discharge expected within 30 days
[illegible] Y.	4/6/63	10/31/75	Family (Mother)	Hyperkinetic Reaction	Discharge expected within 30 days
[illegible] S.	12/26/71	10/31/75	Hinesville M. H. Clinic (Grandmother Guardian)	Non-psycotic Organic Brain Syndrome Due to Brain Trauma	11/15/75

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HOSPITAL Southern Regional Vol. Patients less than 18 years of age in Mental Hospitals (Incl M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	12/17/59	9/24/74	DFCS	Hebephrenic Schizo.	12/1/75
[illegible]	2/14/61	9/15/75	Parents	Unsoc. Aggr. Reac. to Childhood	
[illegible]	12/18/63	9/27/75	Mother	Episodic Rage Reac.	12/6/75
[illegible]	5/19/64	9/11/75	DFCS	Unsoc. Aggr. R. of Childhood	12/11/75
[illegible]	2/26/62	9/22/75	Parents	Unsoc. Aggr. R. of Adoles.	12/19/75
[illegible]	8/7/65	10/6/75	DFCS	Unsoc. Aggr. R. Of Childhood	
[illegible]	11/29/61	10/9/75	DFCS	2 Mod. Mental Retardation, Unsoc. Aggr. R. of Adol.	12/[illegible]/75
[illegible]	10/[illegible]/60	10/15/75	Mother	Hysterical Neurosis w/convulsive Reac.	11/31/75
[illegible]	1/17/63	10/27/75	Mother	Hysterical Neurosis w/convulsive Reac.	11/14/75
[illegible]	4/22/58	10/29/75		Alcohol Addiction Drug Dependence Anti-Social Personality	12/2/75

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[illegible] Vol. Patients less than 18 years of age in Mental

[illegible] (not M.R. Units) on October 31, 1975. INPATIENTS.

Name & Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	3/7/59	10/16/75	Father	Depressive Neurosis Rule out Drug Dependency, Adjustment Reac. to Adol.	11/4/75
[illegible]	12/1/58	10/14/75	Father	Acute Depression & Drug Overdose	2 - 4 mos.
[illegible]	3/4/59	10/19/75	Mother	Adjustment Reac. to Adolescence	1 month - waiting for placement
[illegible]	5/7/61	8/17/72	Father	Childhood Autism	Indefinite (no other facility appropriate
[illegible]	4/27/56	8/6/73	Father	Moderate MR	Impossible to predict
[illegible]	10/26/62	7/30/74	Mother	Psycotic Org. brain syndrome, blindness, MR	March - Academy for Blind
[illegible]	5/3/63	7/14/72	Mother	Borderline Psycotic	1 year at least
[illegible]	10/31/62	7/18/73	Caseworker DFCS	Moderate to mild retardation Unsoc. Aggr. Type	11/13/75
[illegible]	1/24/59	10/30/75	Mother	Extreme family conflict - Hysterical personality disorder	12/16/75
[illegible]	2/18/[illegible]	11/26/73	Father	Hyperkinesis & Min. brain disfunction	*January. 1976

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[illegible] Vol. Patients less than 18 years of age in Mental

[illegible] (not M.R. Units) on October 31, 1975. INPATIENTS.

Name & Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	5/18/62	1/31/74	Brought in by parents - signed in by caseworker	MR, Unsoc. Aggr. Reaction to Childhood	February, 1976
[illegible]	1/26/62	5/1/74	Father	MR, Child Schizo.	6/76
[illegible]	3/28/64	6/4/74	Stepmother	Character Disorder	Impossible to predict Within 6 months
[illegible]	5/21/62	10/24/75	Mother	Unsoc. Agg. Reac.	Anytime - waiting for placement
[illegible]	6/9/58	8/22/74	Mother	Schizo. Undetermined type	12/5/75
[illegible]	11/8/63	6/5/75	Mother	Adjustment Reac. of Childhood	End of May to Group Home if available
[illegible]	10/29/65	4/22/75	Caseworker	Unsoc. Agg. Reac. to Childhood	End of Feb. to Group Home
[illegible]	4/3/60	10/14/75	Mother	Depression, Suicidal ideations	Unknown, waiting for placement, Approx. 2 mos.
[illegible]	6/24/65	7/7/75	Mother	Schizo. Reac. of Childhood	1/76
[illegible]	1/31/59	9/9/75	Mother	Adol. Adjustment Reaction, Schizo. personality	12/19/75
[illegible]	7/20/65	9/22/75	Mother	Childhood Schizo	End of Jan. 1976
[illegible]	11/1/64	9/24/75	Mother	Rule out Psychosis with strong overtones	February, 1976

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[illegible] GEMI Vol. Patients less than 18 years of age in Mental Hospitals (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
T. S.	2/16/58	10/9/75	Mother	Depressive Neurosis & Mild MR	11/13/75
E. C.	5/18/67	10/20/75	Mother	Hyperkinetic Reac. of Childhood	January, 1976
S. S.	10/24/65	10/23/75	Father	Withdrawing Reac. of Childhood, Hyperkinetic Reac. of Childhood, Cerebral paralysis, Blindness	11/24/75
D. B.	12/28/60	10/23/75	Father	Rule out MR	11/17/75

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PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
[illegible].L.	10-20-63	5-19-70	Parents	On Adm: Hyperkinetic Reaction Now: Hyperkinetic Reaction	Impossible to predict
[illegible].L.M.	8-00-62	6-25-70	Stephens County DFCS	On Adm: Emotionally Disturbed Now: Unsocialized Aggressive Reaction	Impossible to predict.
[illegible].L.J.	10-28-61	1-7-72	Local Health Dept.	On Adm: Unsocialized Aggressive Reaction of childhood, Borderline Mental Retardation. Now: Unsocialized Aggressive Reaction	Discharged 12-2-75
[illegible].B.	11-13-57	2-1-72	Trans	On Adm: Schizophrenia, Chronic Undifferentiated Type. Now: Schizophrenia, Chronic Undifferentiated Type.	Long term hospitalization, no immediate plans for release
[illegible].A.L.	7-1-63	10-5-72	Floyd County DFCS	On Adm: Adjustment Reaction of Childhood. Now: Over anxious reaction or childhood, adjustment reaction of childhood	Impossible to predict
[illegible].R.M.	4-1-59	2-5-73	Bibb County DFCS	On Adm: Adjustment Reaction of adolescence. Now: Adjustment Reaction of adolescence.	Two months
[illegible].E.T.	3-4-61	2-21-73	Private Physician	On Adm: Adjustment Reaction of childhood, Psychomotor Epilepsy Now: Organic Brain Syndrome, Brain Trauma	If Day Program opens in Houston County, he will be discharged
[illegible].M.T.	3-18-58	10-1-75	Mother	On Adm: Schizophrenic, Acute Type Now: Schizophrenic, Chronic Undifferentiated Type.	Anytime on temporary visit

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PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
J.F.W.	2-27-65	8-14-73	Family	On Adm: Adjustment reaction of childhood. Now: Adjustment Reaction of childhood	Should be if father appears.
A.N.W.	12-20-57	9-20-73	Crisp County DFCS	On Adm: Adjustment Reaction of Adolescence. Now: Depressive Neurosis, Unsocialized Aggressive Reaction Adolescence	Three weeks.
W.M.B.	11-7-58	5-20-74	Gracewood State Hospital	On Adm: Mental Retardation, moderate with unknown prenatal influence Now: Mental Retardation, moderate with unknown prenatal influence	Psychotic - when condition improves may be transferred to Developmental Disability Center or Gracewood, probably never function outside Hosp, with major psychiatric disorder.
C.W.P.	9-25-63	6-13-74	Family	On Adm: Deferred Now: Unsocialized Aggressive reaction, acute schizophrenic episodes	Not yet
G.V.H.	9-10-64	7-16-74	Thomas County DFCS	On Adm: Adjustment reaction Now: Unsocialized Aggressive Reaction	Transferred to Southwestern State Hospital 12-17-75
J.D.	10-21-61	7-31-74	Putnam County DFCS	On Adm: Reaction of adolescence Now: Adjustment reaction of adolescence, Borderline Mental Retardation with an unspecified condition	Discharged 12-8-75 Readmitted 12-17-75
D.M.D.	12-2-57	1-23-75	Central State Hospital Police	On Adm: Borderline Mental Retardation Now: Mental Retardation border with infection	Impossible to predict.
M.H.	5-14-58	3-17-75	Mother	On Adm: Adjustment Reaction of Adolescence. Now: Schizophrenia, latent type	Three months
J.F.K.	5-23-58	12-5-74	Whitfield County DFCS	On Adm: Deferred Now: Adjustment Reaction of Adolescence Schizophrenia, Paranoid Type by history to be ruled out.	Thirty days.

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PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
J.E.B.	1-6-61	3-31-75	Floyd County DFCS	On Adm: Unsocialized aggressive reaction of childhood Now: Adjustment reaction of adolescence	Will be discharged upon return from Christmas
G.M.	2-21-68	4-2-75	Mother	On Adm: Behavior disorder of childhood, hyperkinetic reaction,R/O Organic Brain Syndrome associated with other physical condition Now: Organic Brain Syndrome, Intracranial Infection	Will be discharged 12-19-75
L.R.J.	11-23-60	6-20-75	Mother	On Adm: Adjustment Reaction to adolescence Now: Adjustment Reaction of adolescence, Runaway reaction of adolescence	Discharged 11-19-75
W.D.S.	11-29-59	6-24-75	Caseworker, DFCS	On Adm: Explosive Personality (Epilipetoid Personality Disorder) Now: Explosive personality	Impossible to predict.
F.P.	11-7-67	7-11-75	Bibb County DFCS	On Adm: Rule out overanxious reaction, Adjusted reaction to childhood Now: Adjusted reaction of childhood, Childhood schizophrenia	Discharged 11-6-75
P.L.F.	11-30-59	7-31-75	Georgia Baptist Children's Home	On Adm: Adjusted reaction of adolescent Now: Adjustment reaction of adolescent	Discharged 11-13-75
D.G.	1-13-61	8-8-75	Fulton DFCS	On Adm: Explosive personality, Adjustment Reaction of adolescence Now: Adjustment reaction of adolescence	Discharged 12-17-75
M.K.C.	2-7-62	8-13-75	Mother & Health Department	On Adm: Schizophrenia, acute episode Now: Hysterical neurosis, Conversion type.	Pending notice of transfer to Talmadge

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	PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
59	A.C.R.	1-20-61	8-26-75	Mother	On Adm: Mild Mental retardation Now: Mental Retardation, Mild with other condition.	To be discharged 12-20-75
35	G.G.	4-19-58	9-5-75	Vocational Rehab.	On Adm: Depressive Neurosis, explosive personality Now: Non-psychotic OBS due to brain trauma	June 1976
74	J.C.C.	8-26-61	9-8-75	Mental Health Center Dr. Jim Kirby, Psy. Warner Robins Mental Health Center	On Adm: Mild Mental Retardation, rule out accompying major psychotic disorders Now: Mental Retardation, mild with unknown prenatal influence	Extended treatment planned Not ready to be released Impossible to predict.
54	L.D.	4-7-61	9-12-75	Family	On Adm: Schizophrenia, Hebephrenic Now: Schizophrenia, Hebephrenic	Discharged 12-4-75
2	M.E.L.	2-23-63	9-15-75	Court Social Worker & Mother	On Adm: Alcoholism, alcohol addiction Depressive reaction Now: Unsocialized agressive reaction	Court will take her as soon as psychological is done
3	J.S.	1-27-60	9-22-75	Father	On Adm: Mild Mental Retardation Adjustment reaction of adolescence Rule out psychomotor seizures Now: Mental Retardation Mild, with unknown prenatal influence	Discharged 11-17-75
1	S.H.	4-1-61	9-24-75	DFCS	On Adm: Schizophrenia, paranoid type hallucenatory Now: Adjustment reaction of adolescence	Discharged A.M.A. 12-4-75
2	W.H.	9-20-59	9-25-75	Parents	On Adm: Non psychotic OBS Now: Hysterical neurosis conversion type	Three months - Temporary visit within period.
3	W.F.W.	7-17-65	10-6-75	Father	On Adm: Non psychotic OBS with epilepsy Now: Non psychotic OBS with epilepsy	Discharged 12-10-75

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	PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
1	L.C.	9-10-61	10-14-75	Mother	On Adm: Deferred Now: Mild Mental Retardation due to unknown prenatal influence	Discharged 11-6-75
1	K.P.C.	6-23-63	10-17-75	Parents	On Adm: Adjustment reaction of adolescence Now: Hyperkinetic reaction of adolescence	Impossible to predict.

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ATTACHMENT "A"

To Post-Discovery Brief of Plaintiffs

HOSPITAL	MENTAL RETARDATION GROUP I 310-315	ORGANIC BRAIN SYNDROMES GROUP II 290.0-294.8 309.0-309.9	PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS GROUP III 295.0-298.0
SOUTHWESTERN ALOS 100	1. 70		1. 397
CENTRAL STATE ALOS 455	2. 1423 3. 114 4. 97 5. 55 6. 22 7. 61 8. 330 9. 570	1. 1024 2. 257 3. 66 4. 64	2. 115 3. 88 4. 90
ATLANTA REGIONAL ALOS 161	1. 25 2. 61 3. 100		1. 24 2. 122 3. 6 4. 151 5. 60 6. 379 7. 97 8. 105 9. 157 10. 185
G.M.H.I. ALOS 346	4. 859 5. 857 6. 24	1. 1215 2. 500	11. 1244 12. 589 13. 468 14. 158 15. 100 16. 83 17. 81
AUGUSTA REGIONAL ALOS 92	7. 34 8. 67		18. 193 19. 261
SAVANNAH REGIONAL ALOS 127	9. 43 10. 158	1. 15	20. 163 21. 665 22. 103 23. 111 24. 79 25. 54
WEST CENTRAL ALOS 71	11. 179	2. 28	26. 38 27. 38 28. 32 29. 65
TOTALS	20/5149=257	8/3169=396	33/6501=197

(ALOS = Average Length of Stay)

State-wide ALOS = 140/34988 = 249.9 days
Without Group I = 248.6 days

NEUROSES GROUP IV 300.0-300.8	PERSONALITY DISORDERS GROUP V 301.0-304.8	PSYCHOPHYSIOLOGIC DISORDERS GROUP VI 305.0-305.9	SPECIAL SYMPTOMS GROUP VII 306.0-306.9
1. 45 2. 17	1. 32		
3. 105	2. 124 3. 1414 4. 77		
	1. 30 2. 103 3. 730 4. 22		
1. 18 2. 60 3. 60 4. 34	5. 46 6. 556		
5. 34	7. 42		
	8. 24		
6. 106 7. 26	9. 172		
10/510=51	13/3372=259	0	0

TRANSIENT SITUATIONAL DISTURBANCES	BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE	CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER	NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE
GROUP VIII	GROUP IX	GROUP X	GROUP XI
307.0-307.4	308.0-308.9	316.0-316.9	319.0-319.3
1. 99	1. 90		
	2. 90		
	3. 88		
	4. 70		
2. 850 9. 375	5. 2035		
3. 493 10. 272	6. 1998		
4. 255 11. 818	7. 1165		
5. 151 12. 945	8. 547		
6. 103	9. 515		
7. 127	10. 76		
8. 60	11. 258		
1. 225	1. 583		
2. 60	2. 150		
3. 56	3. 749		
4. 190	4. 680		
5. 233	5. 51		
	6. 55		
	7. 31		
6. 85			
7. 220			
8. 106			
9. 13			
0. 66			
1. 105			
[illegible]. 37			
[illegible]. 20			
4. 51	8. 225		
5. 69	9. 218		
	10. 30		
	11. 44		
[illegible]. 184	12. 58		
[illegible]. 93			
[illegible]. 69			
[illegible]. 25			
[illegible]. 14			
[illegible]. 12			
/6481=196	23/9806=426	0	0

126 MENTAL DISORDERS

TABLE 1

List of DSM-II Diagnoses and Code Numbers†

I MENTAL RETARDATION
- 310. Borderline
- 311. Mild
- 312. Moderate
- 313. Severe
- 314. Profound
- 315. Unspecified

With each: Following or associated with
- .0 Infection or intoxication
- .1 Trauma or physical agent
- .2 Disorders of metabolism, growth, or nutrition
- .3 Cross brain disease (postnatal)
- .4 Unknown prenatal influence
- .5 Chromosomal abnormality
- .6 Prematurity
- * .7 Major psychiatric disorder
- * .8 Psycho-social (environmental) deprivation
- .9 Other condition

II ORGANIC BRAIN SYNDROMES (OBS)

A PSYCHOSES

Senile and pre-senile dementia
- 290.0 Senile dementia
- 290.1 Pre-senile dementia

Alcoholic psychosis
- * 291.0 Delirium tremens
- * 291.1 Korsakov's psychosis
- * 291.2 Other alcoholic hallucinosis
- * 291.3 Alcohol paranoid state
- * 291.4* Acute alcohol intoxication*
- * 291.5* Alcoholic deterioration*
- * 291.6* Pathological intoxication*
- 291.9 Other alcoholic psychosis

Psychosis associated with intracranial infection
- 292.0 General paralysis
- 292.1 Syphilis of CNS
- 292.2 Epidemic encephalitis
- 292.3 Other and unspecified encephalitis
- 292.9 Other intracranial infection

Psychosis associated with other cerebral condition
- 293.0 Cerebral arteriosclerosis
- 293.1 Other cerebrovascular disturbance
- 293.2 Epilepsy
- 293.3 Intracranial neoplasm
- 293.4 Degenerative disease of the CNS
- 293.5 Brain trauma
- 293.9 Other cerebral condition

Psychosis associated with other physical condition
- 294.0 Endocrine disorder
- 294.1 Metabolic and nutritional disorder
- 294.2 Systemic infection
- 294.3 Drug or poison intoxication (other than alcohol)
- * 294.4 Childhood [illegible]
- 294.8 Other and unspecified physical condition

B NON-PSYCHOTIC OBS
- 309.0 Intracranial infection
- * 309.13* Alcohol* (simple drunkenness)
- * 309.14* Other drug, poison or systemic intoxication*
- 309.2 Brain trauma
- 309.3 Circulatory disturbance
- 309.4 Epilepsy
- 309.5 Disturbance of metabolism, growth, or nutrition
- 309.6 Senile or pre-senile brain disease
- 309.7 Intracranial neoplasm
- 309.8 Degenerative disease of the CNS
- 309.9 Other physical condition

III PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY

Schizophrenia
- 295.0 Simple
- 295.1 Hebephrenic
- 295.2 Catatonic
- * 295.23* Catatonic type, excited*
- * 295.24* Catatonic type, withdrawn*
- 295.3 Paranoid
- * 295.4 Acute schizophrenic episode
- * 295.5 Latent
- 295.6 Residual
- 295.7 Schizo-affective
- * 295.73* Schizo-affective, excited*
- * 295.74* Schizo-affective, depressed*
- 295.8* Childhood*
- 295.90* Chronic undifferentiated*
- 295.99* Other schizophrenia*

Major affective disorders
- 296.0 Involutional melancholia
- 296.1 Manic-depressive illness, manic
- 296.2 Manic-depressive illness, depressed
- 296.3 Manic-depressive illness, circular
- * 296.33* Manic-depressive, circular, manic*
- * 296.34* Manic-depressive, circular, depressed*
- 296.8 Other major affective disorder

Paranoid states
- 297.0 Paranoia
- * 297.1 Involutional paranoid state
- 297.9 Other paranoid state

Other psychoses
- 298.0 Psychotic depressive reaction

IV NEUROSES
- 300.0 Anxiety
- 300.1 Hysterical
- * 300.13* Hysterical, conversion type*
- * 300.14* Hysterical, dissociative type*
- 300.2 Phobic
- 300.3 Obsessive compulsive
- 300.4 Depressive
- * 300.5 Neurasthenic
- * 300.6 Depersonalization
- * 300.7 Hypochondriacal
- 300.8 Other neurosis

TABLE 1 (continued)

V PERSONALITY DISORDERS AND CERTAIN OTHER NON—PSYCHOTIC MENTAL DISORDERS

Personality disorders

301.0 Paranoid
301.1 Cyclothymic
301.2 Schizoid
+ 301.3 Explosive
301.4 Obsessive compulsive
+ 301.5 Hysterical
+ 301.6 Asthenic
301.7 Antisocial
301.81* Passive - aggressive*
301.82* Inadequate*
301.89* Other specified types*

Sexual deviation

+ 302.0 Homosexuality
+ 302.1 Fetishism
+ 302.2 Pedophilia
+ 302.3 Transvestitism
+ 302.4 Exhibitionism
+ 302.5* Voyeurism*
+ 302.6* Sadism*
+ 302.7* Masochism*
302.8 Other sexual deviation

Alcoholism

+ 303.0 Episodic excessive drinking
+ 303.1 Habitual excessive drinking
+ 303.2 Alcohol addiction
303.9 Other alcoholism

Drug dependence

+ 304.0 Opium, opium alkaloids and their derivatives
+ 304.1 Synthetic analgesics with morphine - like effects
+ 304.2 Barbiturates
+ 304.3 Other hypnotics and sedatives or "tranquilizers"
+ 304.4 Cocaine
+ 304.5 Cannabis sativa (hashish, marihuana)
+ 304.6 Other psycho - stimulants
+ 304.7 Hallucinogens
304.8 Other drug dependence

VI PSYCHOPHYSIOLOGIC DISORDERS

305.0 Skin
305.1 Musculoskeletal
305.2 Respiratory
305.3 Cardiovascular
305.4 Hemic and lymphatic
305.5 Gastro - intestinal
305.6 Genito - urinary
305.7 Endocrine
305.8 C f special sense
305.9 C pe

VII SPECIAL SYMPTOMS

306.0 Speech disturbance
306.1 Specific learning disturbance
+ 306.2 Tic
+ 306.3 Other psychomotor disorder
+ 306.4 Disorders of sleep
+ 306.5 Feeding disturbance
306.6 Enuresis
+ 306.7 Encopresis
+ 306.8 Cephalalgia
306.9 Other special symptom

VIII TRANSIENT SITUATIONAL DISTURBANCES

307.0* Adjustment reaction of infancy*
307.1* Adjustment reaction of childhood*
307.2* Adjustment reaction of adolescence*
307.3* Adjustment reaction of adult life*
307.4* Adjustment reaction of late life*

IX BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE

+ 308.0* Hyperkinetic reaction*
+ 308.1* Withdrawing reaction*
+ 308.2* Overanxious reaction*
+ 308.3* Runaway reaction*
+ 308.4* Unsocialized aggressive reaction*
+ 308.5* Group delinquent reaction*
308.9* Other reaction*

X CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON—SPECIFIC CONDITIONS

Social maladjustment without manifest psychiatric disorder

+ 316.0* Marital maladjustment*
+ 316.1* Social maladjustment*
+ 316.2* Occupational maladjustment*
316.3* Dyssocial behavior*
+ 316.9* Other social maladjustment*

Non—specific conditions

+ 317* Non - specific conditions*

No Mental Disorder

+ 318* No mental disorder*

XI NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE

319.0* Diagnosis deferred*
319.1* Borderline*
319.2* Experiment only*
319.3* Other*

†Many of the titles here are listed in abbreviated form.
+ are new diagnoses, that do not appear in DSM-I.

ATTACHMENT "B"

To Post-Discovery Brief of Plaintiffs

QUESTIONABLE ADMISSIONS: DIGEST OF SELECTED PATIENT ADMISSION NOTES

Pursuant to plaintiff's request for documents and in response to plaintiff's interrogatories, each regional hospital superintendent submitted admission notes and social summaries of the members of plaintiffs' class currently confined in these institutions as exhibits in their respective depositions.

Due to the voluminous nature of these documents the originals were not attached to the depositions filed with the court. Rather the plaintiffs are hereby attaching digests of the summaries referred to in plaintiffs' Post-Discovery Memorandum. The complete summaries are available to the Court and/or the defendants upon request.

QUESTIONABLE ADMISSIONS

832-00-2191 — 14 y/o WM admitted to Savannah Regional on 10-6-75...when pt. 3 y/o tried to choke his brother...hyperactive... talks too much according to mother...masturbates a lot... too affectionate...nervous...father beats pt.'s head against wall and uses cruel and unusual punisment. Impression: For whatever reason, Loren is the scapegoat to the degree that the whole family attitude is detrimental to normal growth and development of the child, and it would certainly seem that placement away from the family is the only hope for Loren to reach any kind of social adjustment. In the background with the father using cruel and unusual punishment, coupled with the lack of love and understanding from other members of the family, the father's preparation to take Loren hunting and teaching him to shoot, could well lead to a family conspiracy of murder through the child.

255-[illegible]-9362 — 11 y/o BM admitted to Savannah Regional on 10-29-75...referred as being hysterical and out of control...mother stated that when pt. was discharged after previous admission, she was unable to get the medication and pt. was off the medicine until 4-5 months ago...medicine prescribed by Dr. Tillinger caused vomiting and headaches...pt. referred to in the community as the "little preacher" because of his preaching and shouting ...goes to the Holiness Church...states he likes to tease people and tell them he sees things and ringing and shouting ...mother does not see his behavior as so destructive...no indication of psychosis since admission but he often tells "tall tales" and gets into minor mischief.

832-00-2238 — 15 y/o BF admitted to Savannah REgional on 11-14-75...apparently attempted suicide by swallowing an unknown numbe: of pills... 2 suicide notes, one in verse, other to mother...pt. has run away from home 6 times...mother filed unruly charge against her...CMH psychiatrist felt mother was distrubed...CMH would accept a referral back for pt. but are not able to come because of work pressure...impression is strong problem lies more with mother and family situation.

832-00-1063 — Female admitted to Savannah Regional on 8-24-75...4th admission...readmitted because of similar past behavior...leaving home without mother's permission, sitting on bridge w/ dress up...calling former male pt. from Ga. Regional, attempting to entice him to have sex and generally out of control of mother ...it was felt at admission pt. was not psychotic...it is definitely impossible for this girl to return home and a placement is the only possible solution although because of her acting out, will be very difficult to find facility agreeable to working w/ her...child and adolescent co-ordinator had been working...to have pt. readmitted to public school... naturally when pt.'s mother readmitted her, these plans went down the drain.

832-00-1766 — 16 y/o BM readmitted to Savannah Regional on 7-22-75...recommendation at time of discharge in May was an alternate home placement, such as foster placement and either vocational training or job corps...this recommendation was not carried thru and pt. was allowed to return home w/ supervision by DFCS and MHC...decision made to readmit for stabilization on medication and evaluation for VR services and placement... because of his mother's inability to relate info correctly, it is not known exactly what pt.'s behavior has been like since his discharge.

260-98-113[illegible] — 14 y/o male readmitted to Savannah Regional on 5-7-75...unmanageable in the foster home...but there was no class in special education available to John. As frustration increased, John became more aggressive, and was suspended from school, and the _____ again asked to have him removed because they were unable to handle him...Impression: This is a boy who was deprived cuturally, starved and beaten in his early years, and never received adequate nurturing. He is easily frustrated,

and there has been no special education available to give him more individual training. He is ingratiating with adults, but is unable to make friends with his peer group. Despite this, because he is older, group placement rather than foster home placement is recommended because professional personnel is better equipped to handle his special problems in adjustment.

831-00-1907 — 8 y/o boy admitted to Augusta Regional on 10-27-75...difficulty in school...teacher feels she cannot cope w/ him in the classroom...at times threatened to kill himself and has talked to himself...mother expressed concern that due to his behavior she might hurt him...mother evidences continuous depression... reacts at home, in school and at the babysitter's with verbal hostility and "screaming". He has threatened to kill himself. He has begun to talk aloud saying he is "telling the devil" to leave him alone. After two years of psychiatric treatment, hospitalization was recommended to the mother because of her own difficulties in functioning. She was rejecting of this and has sought no further help for herself.

[illegible]-2543 — 7 y/o WM admitted to Augusta Regional on 9-22-75...his parent described his behavior as being hyperactive; he was also described as having a short attention span and having easy distractability and having run away. His parents seemed to feel they could not cope with this problem on their own...they requested he be admitted here...when seen, this young boy did not appear particularly hyperactive; however, this is frequently the case during an interview situation...there were no gross signs of psychosis, neurosis, or severe mental retardation.

831-00-3203 — 14 y/o boy admitted to Augusta Regional on 10-8-75...behavior problem...had a history of extreme acting out behavior...was brought to the center after he stole his father's car and wrecked it...has also run away from home on numerous occasions ...has experimented with marijuana on two occasions, but denies any other drug-related problems...patient is alert...is well-mannered and well-dressed...does not seem to be retarded or show signs of organicity...there are no signs of psychosis, severe neurosis...is oriented times time three...there are no signs of mental deficiency...since mon's death, pt. appears bored w/ school and has threatened and angered father...began when father talked about mother and [old times].

261-57-7450 — 16 y/o Male admitted to Augusta Regional on 10-24-75... being mistreated by parents...he has had some difficulty with rebellious behavior...this has consisted of some acting out and hostility toward his stepfather...on the day prior to his admission here, he called the Department of Family and Children Services and requested to talk with a Miss Rivers...he was seen by Miss Rivers who stated he would not return home...he stated his mother had threatened him and that he did not get along well with his stepfather...his mother denied this to our social worker here...rather than go home, he was placed overnight in jail and the next day was seen by a physician who recommended hospitalization...this is a very alert and intelligent young man...he relates in a quite mature manner...there is no evidence of any psychosis or severe depression or any neurosis...there is no evidence of any organicity and certainly no evidence of any mental retardation...this young man's assets come out very strongly in the mental status interview.

251-57-2450 — 13 y/o male admitted to Augusta Regional on 11-11-75...running away from ho ..pt.'s mother had brought the patient to the CAAP Community Service Center due to what she saw as "homosexual behavior"...he also had nightmares, sleep-walking and episodes of running away from home...his mother felt that when he was in a foster home at age eight, he developed some homosexual attitudes towards males...also he had just recently experienced episodes of running away from, which his mother seemed to feel was secondary to his "homosexuality"...mother seemingly has difficulty maintaining herself, emotionally and financially...the pt. was cooperative and friendly...he was neatly dressed...there was no evidence of delusions or hallucinations or severe depression.

434-00-0227 — 13 y/o WM admitted to W. Central Regional on 11-13-75... admission due to chronic truancy, poor peer relationships and academic failure...speech clear coherent and relevant...no losseness or flight of thoughts...affect of mild depression... no thought disorder detected...no hallucinations...general info very poor...judgement poor insight 0...while sitting "quietly" is in constant motion...MCD w/ reading disability.

834-00-0166 — 9 y/o WM ad-itted to W. Central Regional on 10-6-75...expelled from special classes for uncontrollable behavior...no behavior problems at home...alert cooperative appropriately behaving... good eye contact and sense of humor...no thought disorder... no flights...doesn't know what gets him angry but he does admit to spells of anger

260-21-5860 — 14 y/o BF admitted to W. Central Regional...reported to be aggressive and disruptive in school and plans are afoot to expel her...an alert cooperative adolescent...speech clear, coherent and relevant...no flight or looseness...mild depression...judgment and insight present...due to lack of community resources, referred to hospital.

830-01-4117 — 13 y/o BF admitted to Atlanta Regional on 10-22-75.

253-11-1743 — 17 y/o BF admitted to Atlanta Regional from CSH on 10-14-75.

7 — admitted to GMHI on 10-18-75...admission at this time seems to be related to the great amount of family conflict at home ...no indication of a thought disorder...associations good and memory intact...although talks of suicide, no indications that he actively plans to kill self or make any suicidal attempts at this time...reports no hallucinations.

8 — 15 y/o WF readmitted to GMHI for 5th time on 11-7-75 from devereaux school...CHIEF COMPLAINT: the pt. was brought to the hospital on a friday afternoon at approximately five or six o'clock after a daylong episode of uncontrollable behavior. ..this behavior, including throwing rocks at the treatment home psychiatrist's car, throwing a chair, threats to hurt the staff, demanding behavior and general uncontrollable behavior...the Devereaux School stated they had no absolute security sections and could not contain this type of behavior. the pt. was brought in without the community being notified and the hospital was only notified once the pt. was in transit. the Community was quickly notified. the pt. says she came because she was slapped by a staff member(this probably occurred because of hysterical behavior on the pt.'s part as a way of bringing her back to reality, but this is only speculation) Also there had been a call to her grandparents a day or two before and this had upset the pt. because the grandparents were intoxicated and pt. had called to ask them about a trip to them for Christams. A third factor that may have something to do with the hospitalization involved the therapist on Unit Pt. was aware that this therapist was leaving and that the following week was to be the therapist's final week on the unit. It is a possibility this is a conscious or subconscious attempt to see the therapist before his leaving...this is an institutionalized child who knows all of the institutional ways to express craziness and get need taken care of.

29. — Reason for modality change [hospitalization] is due to fact that father is dying of cancer...grief mom and pt. feel is so upsetting that he can no longer be managed at home...

800-4190-083 — 8 y/o WF admitted to CSH 8-14-73...father states he and his wife have been diforced and his ex-wife was not the best example for the child...she used to live a promiscuous life ...he says he remarried and his daughter was awarded to his father by the court, who died of cancer, and since he has been taking care of the child...she says the child cannot concentrate and it is difficult for her to learn...she is involved in sexual activity with a boy her age, meaning kissing and petting...this upset the whole family...pt. states that she has only one problem, that when she reads a book, she does not read the same as other people do. she says she cannot understand very well...pt. very nervous.

800-201-514 — 11 y/o BM re-admitted to CSH on 1-29-75...mother states that the pt. is practically doing alright at home and his relation w/ the family especially w/ the children is quite excellent ...he also plays in the neighborhood w/out creating any problems...two weeks ago he hit his head against a bookcase sustaining a hematoma on his head...three days afterwards that incident he accidentally poured some battery acid on his thigh causing some ulceration...the day prior to admission he ran into a boy unintentionally or accidentally...he said he never had any quarrels with his fellow classmates, instead he is friendly, but his teacher complained that he is naughty... when asked in what way, he could not answer...pt. is fairly developed, and nourished, conscious, coherent, black male in no acute distress...affect is appropriate.

800-209-668 — 14 y/o BF admitted to CSH on 11-12-75...referred by the Montgomery County DFCS as a result of discovery of a four-year history of incest and charges being brought against the father. has been placed in custody of her real mother whom she has not seen for eleven years...she had difficulty adjusting at school, was suspended for accusing the assistant-principal (of 20 years employment) of kissing her...is manipulative with little self-discipline and is easily led...very cooperative...speech was coherent and relevant...train of thought was logic... affect was appropriate although showed some hostility when asked about her relations with her father...did not elicit any delusional system at the time of the interview...denies hallucinations, illusions or misinterpretations...oriented in all the spheres and memory was good for recent and remote events...has a good fund of general information...has some insight, judgment intact...recommendation: placement in good foster home or group home.

800-193-966 — 15 y/o WM admitted to CSH for 1st admission on 2-5-73...it appears that pt.'s expulsion from school was the precipitating crisis leading to his hospitalization at Central State Hospital ...I find it interesting that pt. and the foster mother were not involved in out-patient treatment at the Bibb Co. Mental Health Clinic during his placement with them...there is a religious fervor about the foster mother that I initially distrust...I can't help but wonder if she feels religion is the cure.

D — 17 y/o WF readmitted to CSH on 11-29-75...argument with her father this morning because she left home yesterday afternoon and she didn't come back until this morning...she admitted some marijuana smoking but only occasionally.

800-209-690 — 16 y/o BM readmitted to CSH on 11-12-75...about 3 or 4 weeks prior to his admission he ran out of medication and his mother stated she was unable to get a new supply...he became angry that they were unable to handle him, called her welfare worker and his readmission here was arranged.

800-209-308 — 12 y/o WM admitted to CSH on 10-17-75...brought here by his mother...pt. has run away from home 4 times...pt. is very upset crying, saying he wants to go home with his mother and to come back in the morning...he said that if he will be forced to stay here she will run away...pt. is alert but uncooperative... speech was coherent and relevant...train of thought was logic... appropriate...did not elicit any delusional system during the interview...denies hallucinations, illusions or misinterpretations...oriented in all the spheres...memory was fair for remote and recent events...has a regular fund of general info... little insight into his problem...judgement seems to be preserved...parents divorced, poor home environment, adolescent turmoil... short term hospitalization, chemotherapy as necessary, melieu therapy, group therapy, school work and recreational activities...a foster placement seems to be indicated for this young pt.

14 y/o WF admitted to CSH 2nd time on 4-1-75...brought in by caseworker for voluntary admission...this pat. was admitted the last time on 1-14-72...discharged 1-30-75 with the diagnosis of unsocialized aggressive reaction of childhood 303.40...pt. states that she wants to come back in this hospital and through her suggestion with her caseworker she was brought in yesterday for readmission...pt. claimed that she ran away from her residence in March around 30 minutes and while on the road was caught by houseparents and brought back. r. states that the main reason she ran away is that she does not want to be there because "I am staying with 40 blacks and I am the only white" in that place...all of them are teasing her by calling her a "honkie"...she states also that every time she went out on the basketball court, boys and girls but mostly girls would throw rocks at her...on March 13, 1975, while sleeping she was burned on her left thumb by her roommates with sustained blister on her left thumb...pt. is fairly developed and nourished, conscious, coherent, oriented, very quiet, and presenting no signs of aggressive reaction at this time of admission... Impression: Runaway Reaction of adolescence 308.3

REPORT OF THE STUDY COMMISSION ON MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH

November 9, 1973

MARY M. WOOD, Ed.D.
Chairman

PART I

THE COMMISSION'S APPROACH TO THE TASK

Recognizing the increased need for children and youth mental health services, the Division of Mental Health has placed a high priority on the development of a comprehensive plan for children and youth mental health programs in Georgia. In order to do this, it was determined that the best way to begin was to survey existing services. A group of consultants with experience in community and institutional mental health programs for children and youth was formed, May 1973. This study commission was asked to survey existing programs, analyze needs and make recommendations for development of comprehensive services.

The commission prepared a 37-page reporting form which was used when the commission visited the child and youth units at each of five state hospitals. On each site visit, this format was used by the members of the commission to gather specific information about the program. Following the visit, a staff assistant compiled [2] the individual reports and returned the document to the Superintendent and Unit Director of each hospital for validation. There, the report was reviewed in detail and information which was inaccurate was corrected. This final report is based primarily upon information gathered during the site visits. Additional and substantiating data has been gathered from the Division of Mental Health, Georgia Department of Human Resources. The hospitals visited were:

Savannah Regional Hospital—May 2, 1973 and August 28, 1973

Central State Hospital —May 3, 1973 and September 10, 1973

Augusta Regional Hospital —June 21, 1973 and September 12, 1973

Georgia Mental Health Institute —July 9, 1973 and October 23, 1973

Georgia Regional Hospital at Atlanta —July 10, 1973 and October 11, 1973

The Southwest Regional Hospital was not visited because of the commission's understanding that no child and youth unit has been developed there. However, it has been reported since that some children and youth are presently served at that institution.

[3]

The appendices of this report contain a summary of strengths and weaknesses of the various hospital programs as judged by the commission members. It is important to emphasize that the hospital personnel and the commission have reflected many of the same concerns. There was near consensus agreement between the personnel and commission on most problem areas.

It will be noted that hospital programs are not identified by name in the summaries. It was the unanimous position of the commission that this report should reflect state-wide program progress, strengths, and weaknesses and should recommend directions for the State towards program improvement. It is not the intent of the report to be critical of individual programs.

The appendices also contain summaries of problems as reported by the personnel of these programs. The commission found that personnel of children and youth pro-

grams are keenly aware of problems and have much to offer in constructive suggestions for program improvements.

The individual hospital reports with recommendations specifically directed toward each hospital have been [4] submitted to the Director, Division of Mental Health, and to the Chief of Developmental Services Section.

In addition to those very specific recommendations for each hospital, the commission is aware of a number of problems and issues which are state-wide in nature. Foremost among these issues are the following:

. . . lack of priority for children's services at all levels of administration (including issues of advocates and autonomy)

. . . admission policies and procedures (including the rights of children)

. . . treatment plans and procedures (including out patient services and documentation for program accountability)

. . . shortages of personnel trained in child and youth services (including issues of child and youth training, job responsibilities of the hospitals for training, and pay scales)

. . . responsibility of a hospital's child and youth unit for community services

. . . patient movement and discharge procedures

. . . physical facilities

. . . ways to monitor, evaluate, and plan for needs of children and youth

In response to these problems, the commission has prepared in Part II, a series of fairly specific recom-[5] mendations which could be implemented this year at no

significant cost increase. It is important to understand that the commission does not offer these as a fully developed program plan for children and youth mental health services. Rather, the recommendations contained in Part II, if implemented this year, would provide for some immediate improvement of current conditions and would provide also for collection of data over the next three years with which more informed decisions and program planning could be made.

Given a three-year planning period in which these short-term recommendations are implemented and results evaluated, the State should be able to develop an adequate, comprehensive state-wide mental health service for children and youth.

Finally, the commission is in agreement that there are certain factors unique to children and youth around which a well-conceived service delivery system should be developed. In reviewing the findings and recommendations in this report, it is suggested that the following seven items be used as reference points in judging the current conditions and determining the unmet needs.

[6]

1. Children and youth are still dependent, living and growing under the auspices of others, dependent upon someone else for their psychological maturation and their material and physical well-being.

   A child is dependent upon someone else for identifying his need for help and in seeking assistance. Therefore, there are no true "voluntary" child admissions, and criteria must be established to protect children from needless institutionalization or from the assumption that every child in crisis needs service at a regional hospital.

2. Because of their dependency, treatment for children is complicated; it involves working with those who are significant to the child. Services at the outpatient level, the day treatment level, and at the inpatient level, all within the same institution and with some overlapping of staff are essential. Continuity of service and continuity over age groups are important goals. Creation of direct services in this manner allows a child to move in and out of particular programs in an institution with which he is familiar and with staff with whom he has established a relationship. And furthermore, he may be able to continue in treatment during difficult transitional periods between childhood and adolescence. Therefore, child treatment requires a variety of rich environmental and psychological alternatives, involving many people and experiences in order to provide a responsive environment.
The costs will be greater than for a system which provides benign custodial care. Also, costs for inpatient mental [7] health treatments for children are higher than costs for adults, nationwide.
3. Children and youth are still developing physically, intellectually, socially, and emotionally. This ongoing maturation dictates that there must be a CONTINUITY OF CARE between their home, school, community, and helping agencies such as hospitals and community-based treatment.
4. Children learn from their environment and adapt themselves to it. Such adaptation usually becomes an integral part of the child's personality. A child institutionalized for long periods of time may learn and assimilate "institutionally appropriate" behavior, which in turn is an additional handicap if he is to return to his normal environment. Therefore, all forms of 24-hour care should simulate a normal childhood environment to the extent possible and should maintain regularly scheduled home visiting from the time of initial admission.

5. While certain children do require long-term institutional care, it is extremely important that they receive continued evaluation and reappraisal so that they can be provided alternative forms of care at an optimal time. Therefore, it is imperative that appropriate discharge placement plans be started at the time of admission; this, of course, presupposes a variety of community facilities.
6. Psychological, emotional, and behavioral problems in children usually produce secondary handicaps and problems if not [8] attended to. Therefore, appropriate responsive services provided at onset will be a good investment in the social, emotional, and economic well-being of our State.
7. Children are the most vulnerable group affected by the crisis of growing cities (e.g., transportation, crime, schools, crowding, job pressures on their parents, elimination of play areas, exposure to many different persons with whom they are not prepared to cope). Therefore, we can expect more and different types of emotional, behavioral, and social problems in city children, suggesting a need for a variety of different services in rural and urban areas.

[9]

PART II

SHORT-TERM RECOMMENDATIONS REQUIRING NO SIGNIFICANT COST INCREASES

The commission suggests that State improvement of mental health services to children and youth is urgently needed. A most conservative estimate is 15,371 seriously emotionally-disturbed children and youth (age 16 or younger) needing special services in Georgia.* It is quite likely that this is the number one health problem in Georgia.

Development of appropriate and adequate services should be based upon professional standards, a State plan, citizen advisory participation, and should reflect unmet needs. However, it is very difficult to estimate the needs of mental health services for children and youth in Georgia for a number of reasons:

1. There are no established State program standards.
2. There is no State plan for mental health services to children and youth. There is no data collection system describing present services for children and youth as a basis for intelligent planning.

[10]

3. There are so few appropriate services that recommendations for length of treatment, required "bed space", and alternative services can only be educated guesses. In most of Georgia, for a disturbed child or youth, there are only two sources of service —a Youth Development Center or a Regional Mental Hospital. It is clear that not all disturbed children benefit from either of these types of programs.

*See Appendix, Figure A-1.

The commission suggests that the task before the State should be viewed in three phases:

Phase I—Implementation of urgently needed improvements during this current Fiscal Year and Fiscal Year 1975 with minimal budget increase.

Phase II—Establishment of a three-year Child and Youth Mental Health Task Force to begin July 1, 1974—with a temporary data collection system to be used as an information-base for comprehensive state-wide planning.

Phase III—Implementation of a state-wide system of services with new, more appropriate alternatives to hospital care to be phased-in with careful cost accounting and man-power training programs over a period of several years, beginning in Fiscal Year 1975.

The following recommendations have been prepared by the commission to provide some immediate improvement of current conditions (Phase I) and to initiate a data [11] collection system and program guidelines for beginning Phases II and III.

These recommendations are not all-inclusive, but they reflect major problem areas. The recommendations also reflect a deep concern among the commission members that regional hospitals should be regarded as a resource only for children and youth regarded as seriously emotionally-disturbed, in actual need of hospital care, and that these hospital services become part of a comprehensive area-wide program of services.

The commission supports the position of a majority of professionals involved in child and youth treatment that there are many alternative forms of both 24-hour care

and community-based outpatient care which are preferable alternatives to hospitalization yet, which, with a few notable exceptions, do not exist at present in Georgia.

* * * * *

[24]

Variations and alternatives
to hospital care

RECOMMENDATION: 3

IT IS THE OBSERVATION OF BOTH HOSPITAL PERSONNEL AND THE COMMISSION THAT MORE THAN HALF OF THE HOSPITALIZED CHILDREN AND YOUTH WOULD NOT NEED HOSPITALIZATION IF OTHER FORMS OF CARE WERE AVAILABLE IN COMMUNITIES.

Hospital records indicate that between 50 and 75% of the children and youth currently served in these institutions have no family or are part of severely dysfunctional family units or are in State custody. In addition, the commission's findings indicate that more than half of the hospitalized children are characteristically aggressive, anti-social, hyperkinetic, or run-aways and non-psychotic. This suggests that the child and youth populations at the hospitals are in many respects similar to children classified as youthful offenders.

The commission submits the following list of variations and program alternatives of 24-hour care with the recommendation that the proposed child and youth Task Force consider and advise the Division of Mental Health on establishing a number of these programs as needed as a part of a state-wide program for children and youth.

I. Variations of hospital programs for 24-hour care:

a. Psychiatric hospital inpatient unit: provides psy-

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to hospital care
Page 2

chiatric treatment, nursing care, ancillary therapies, special education, and family services on an emergency, intensive or extensive basis.

[25]

b. Night hospital program: psychiatric hospital unit offering overnight bed space, psychiatric and nursing care; patient is involved in community activities (work or school) during the day.
c. Guest program: psychiatric hospital unit providing a one or two day respite for crisis or emergency; patients are not admitted for treatment.
d. Weekend home policy: psychiatric hospital unit which is closed on weekends or which arranges for its five-day week patients to go home for weekends.
e. "Weekend Only" program: patients who are cared for at home during the week are accepted on weekends on the psychiatric unit; such programs enable patients to have access to psychiatric and nursing care when it otherwise would be unavailable with limited bed space; such programs also reduce costs by involving families in partial 24-hour care.
f. Private psychiatric hospital: under this arrangement, the State would purchase services for emergency or intensive treatment for children and youth at private facilities when families are not able to purchase such services privately, and the needed services are not available at public facilities.
g. Specialized residential hospital (with weekend home and rotating bed programs): for children and youth needing long-term care, alternative care in a specialized residential program offers assistance in self-help skills and in maintaining maturational progress to the extent possible; ordi-

narily children and youth needing such specialized care have limited capacity for returning to normal functioning and will be acclimated toward institutional behavior because of the long-term care needs.

[26]

h. Rotating bed program: more than one patient uses a bed on a rotating basis; particularly effective in interspersing long-term hospital care with periods at home.

II. Variations of 24-hour care not requiring a hospital:

a. Small group crisis home: up to eight children served in a home for temporary or intensive care; psychiatric and nursing services available; admission to crisis homes is on a short-term basis and patient turnover is fairly rapid (eight weeks or under).

b. Small group home: up to eight children requiring a different living situation but not in need of having a specialized treatment environment; psychiatric and nursing care services available on a consultative (or on-call) basis.

c. Specialized small group living home: designed for children needing long-term care of a specialized nature; this varies from the specialized psychiatric hospital in that the program is conducted in a small group home with not more than six children.

d. Small group home clustering: by clustering a number of small group homes in close proximity, it is possible to provide more effective psychiatric and nursing care to a greater number of children; such closeness provides for easy patient movement from home to home; i.e., from a crisis home to a small group, non-crisis home.

e. Therapeutic camp life: generally used for intensive or extended treatment; allows children to participate in a therapeutic environment in a primitive but wholesome setting; psychiatric services available.

[27]

f. Specialized foster parent program: foster families selected to provide specialized foster care to disturbed children; such parents would be assisted through on-going instruction from mental health workers in therapeutic management of their disturbed foster children; a variation of this program would be specialized foster parents for weekends only, thereby providing a hospitalized child without a family a weekend home program.

g. Rotating parent program: parents of children in treatment share in the care of each other's children on daily, weekend, or weekly basis; such a program often provides intermittent relief for parents without having to hospitalize the child. The State should compensate the participating parent on an hourly basis.

h. Home care services: mental health treatment team (based in community or hospital) visits the child's home on a weekly basis, or more frequently if needed, in order to assist the parents in home management; in this way parents are taught treatment procedures and effective management while the child lives at home.

i. Private child care agencies: an arrangement whereby the State purchases care at numerous private child care agencies on a temporary, intensive, or extensive basis at private facilities providing 24-hour child care and treatment ser-

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to hospital care
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vices, when families are not able to purchase services privately and the needed services are not available at public facilities.

III. Outpatient and day treatment program alternatives:

a. Child and youth services at a community mental health center: a component of a community treatment center with staff trained and experienced in children and youth services; major emphasis on supportive services to families and schools.

* * * * *

[51]

Admissions/Policies

RECOMMENDATION: 9

ADMISSION GUIDELINES FOR CHILDREN AND YOUTH TO STATE HOSPITALS NEED TO BE MORE SPECIFIC.

The commission supports the general policy tone indicated in revised Policy Memorandum No. 20-01, dated May 10, 1973.* This policy memorandum makes note that admission policies for "mentally retarded or other developmentally disabled persons"** are currently being developed. However, no reference is made to the need to develop admission policies specific to children and youth.

The commission interprets this policy as stressing the

*See Appendix, p. D-1.

**Currently "developmentally disabled" includes individuals with cerebral palsy, mental retardation and epilepsy, but not emotional disturbance or mental illness.

Admissions/Policies

responsibility of each hospital for obtaining appropriate alternative service when indicated. It should be noted that such a policy is presently difficult to implement because there are so few of the needed alternative services for children and youth.

In particular, the commission stresses the need to protect children and youth from being inappropriately [52] admitted to state hospitals, and guidelines are needed for assisting admissions staff in determining appropriate alternative services.

Careful diagnostic studies should be performed prior to admission in all but acute emergencies, and appropriate service needs should be determined on the basis of such studies.

Children and youth staff should be assigned to admissions with responsibility to see that child and family get to the most appropriate source of service, i.e., implementing the criteria established for admission of children and youth units or alternative services. A temporary, "crisis assistance" person should be available from the child and youth units.

Staff training should be conducted by the Developmental Services Section of the Mental Health Division at each hospital regarding interpretation of Policy No. 20-01 and subsequently developed policy guidelines for admission of children and youth. Such training should include all hospital staff with work assignment in admissions including the hospital's clinical director and all staff involved in admissions from the children and youth units.

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[A-4]

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ADMINISTRATION

The concept of regionalization for children and youth is an improvement over having one central facility in the state. The overall hospital support for the child and youth programs is high. Administrative staff apparently place great emphasis on these services. This support is essential to the development of a high quality program. However, under the present staffing patterns and lack of space for children and youth at the regional hospitals, outpatient and day care services cannot be and therefore have not been developed adequately.

There are certain factors at work which are significantly impeding the current policies of the regional hospital system for improving child and youth services and reducing inpatient length of stay:

(a) type of building: child and youth units generally were designed for long-term treatment. Except for GMHI, none have outpatient or day program space.

The children's buildings are new, well-equipped, and well-maintained. Such a physical plant contributes greatly to a therapeutic environment, but their potential for specialized use for children's programs is greater than their present uses.

Facilities and programs for adolescents are far behind programs for children. There are no separate physical facilities for youth except at GMHI and CSH. At CSH the youth building is such an incredibly [A-5] poor facility as to bring question to its effectiveness in rehabilitation. This building is decrepit and does not provide the privacy and facilities which are a primary element of a therapeutic environment.

Except for GMHI, none of the hospitals have adequate space for adolescents. Each insitution has solved its problem differently and ingeniously considering the limitation. Various arrangements include housing adolescents in children's unit with children (thereby reducing to half the number of available beds for each age group and by half again if sex segregation is maintained). At one hospital, the physical facility for adolescents is so poor that very little treatment can be done (only behavior control for adjusting to institutional expectations). In addition to approximately 85 adolescents housed in the adolescent unit, there are approximately 85 more housed on geographic units with adults.

(b) treatment programs: the programs generally are institutional in character and extremely limited in opportunities for normal childhood experiences.

(c) type of children served at regional hospitals: at three of the five regional hospitals the staff reports that a majority of the children need not be hospitalized if alternative services were available in the community. At the other two hospitals the staff reported that the length of stay could be significantly reduced if there were adequate follow-up services.

Between 50-75% of children served in these institutions have no family or are part of severely dysfunctional family units (e.g., DFCS custody).

[A-6]

More than 50% of children served are characteristically aggressive, anti-social, hyperkinetic or runaways, and non-psychotic. The child and youth population of the regional hospitals in many respects is similar to those identified as youthful offenders, except they have not been sentenced.

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[A-8]

* * * * *

ADMISSIONS

1. Admissions decisions at all but two hospitals are primarily the responsibility of the hospital's central admissions office. Unit staff do not participate in admissions decisions, generally.

[A-9]

2. The hospitals' ability to assure that all the children and youth who are admitted are, in fact, in need of hospital care is seriously limited by the present lack of community alternatives able to provide help to emotionally or behaviorally-disordered children and youth.

3. At present, the units have what is essentially an open admissions policy for children. Since this is in effect an involuntary procedure for the children themselves, there is a major responsibility to at least investigate the appropriateness of alternative resources in the community before accepting them into the hospital. Most units' ability to do this is limited by a lack of alternative community programs, and the children and youth personnel identified this as one of the major problems.

4. The policy at one hospital requiring that all young girls who are pregnant or known mothers be placed on adult geographic units raises questions about the placement procedures for girls between the ages of 12 and 16 years.

* * * * *

[A-14]

* * * * *

DISCHARGE AND COMMUNITY FOLLOW-UP SERVICES

1. Generally, discharge decisions are collectively made at staffings but are not now tied to previously written treatment objectives for each child.

2. At present, discharge is hampered by the lack of intact families to return children to. Few parents are able to take advantage of the services provided at the hospitals themselves and apparently little field work with parents is done. In one instance, the present amount of social work service assigned seriously limits the amount of parent services, field services, and community agency liaison services offered.

3. Community liaison and resources for pre-referral evaluation and post-discharge placement are limited.

4. Some patients stay years because there is no place for them to go and there are only limited comprehensive community services available.

5. Field services with geographically distant communities are not systematically provided.

* * * * *

[1]

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION**

(Caption omitted in printing)

AFFIDAVIT

Personally appeared before me the undersigned officer duly authorized to administer oaths, ROMAE T. POWELL, who states on oath as follows:

1.

I am Romae T. Powell, and I am and have been one of the Juvenile Court judges for the Juvenile Court of Fulton County. I have been in that position for 3 years. In addition, I am a member of the Executive Committee of the Council of Juvenile Court Judges of Georgia, established by Ga. Code § 24A-501. In my capacity as a Judge of the Juvenile Court of Fulton County and as a member of the Executive Committee of the Council of Juvenile Court Judges, I have personal knowledge of the matters set forth in this affidavit and the requisite experience and knowledge to support my opinions which are stated herein. I make this affidavit for use by the defendants in the above-styled action, particularly in support of their application to stay the order of this Court and any judgment thereon pending disposition of the defendants' appeal and offer this in lieu of my testimony since, because of my court's caseload, its demands on my time, and the time limitations provided by the Juvenile Court Code in which to hold hearings (24A-1701(a)), I cannot lose the time which would be required by a personal appearance before the Court.

ATTACHMENT TO
EXHIBIT C

[2]

[2]

2.

I have examined the order of the federal court entered in the above-styled matter on February 26, 1976. For a number of reasons, including those which are set forth in detail below, that order will cause and impose a further burden on what is already an overworked, overburdened juvenile court system and will serve to impede the fair, speedy and equitable administration of justice in juvenile matters.

3.

Initially, there are presently two juvenile court judges who sit in Fulton County. Presently, each of the two judges disposes of approximately ten (10) cases per day, and the juvenile court's four referees dispose of an additional twenty (20) to thirty (30) such cases. The case load which we presently have obviously taxes, almost to our limit, our ability to dispose of cases promptly and in an equitable fashion. Any order or ruling which will increase the caseload of our court will obviously impact on our ability to handle our current caseload.

4.

In addition to the burden imposed by the increase in the caseload, the character of the matters which will be brought before us as a result of the federal court's order will in and of itself have a greater impact on our ability to administer speedy resolutions to our juvenile cases than would a case where the child was alleged only to be delinquent or unruly.

5.

I say this because it is my understanding that most admissions to mental health facilities which are sought by

parents, generally occur when the child is in need of immediate hospitalization, which necessitates taking the child into custody prior to an opportunity for a hearing. Under the Juvenile Court Code, whenever a child [3] is taken into custody without a petition having been filed and an order of the court issued, the child is entitled to an informal detention hearing within seventy-two (72) hours of being taken into custody.

6.

Additionally, the law provides that whenever a child is in custody, the child is entitled to a full adjudicatory hearing within ten (10) days after having been taken into custody. The court has little leeway in this matter and thus, it would be necessary that we adjust our calendars and schedules to accommodate those cases which involve children who have been detained in the mental hospitals, to the detriment of those other pending cases which will have to be delayed while we hear these cases.

7.

Further, the cost of holding these hearings has not been budgeted and is not included in the court's appropriation. The Juvenile Code, as well as the federal court's order, contemplates a proceeding which will be conducted in the nature of an adversarial hearing, with the parents on one side and the child on the other. Under the Code, this will necessitate the appointing of a guardian ad litem in each instance. For private attorneys in this county, we pay a maximum of $250.00 for each juvenile court hearing. Of course, the Code also requires that every hearing be recorded, unless waived, which adds additional costs.

8.

There are other costs which cannot be directly calcu-

lated for the adjudicatory hearing in the juvenile court requires the presentation of evidence on the matters asserted. That is, if it is alleged that the child is mentally ill and in need of hospitalization, evidence to that end will have to be presented to the [4] court. This will require the appearance in court of the mental health personnel who have the expertise to advise and assist the court in reaching a proper disposition of the case. Obviously, if the personnel of the mental health facilities are required to appear in court, the time during which they will be able to direct their talents to more beneficial purposes, will be diminished.

9.

There are additional immediate problems with respect to the federal court's order. In the past, it has brought to the juvenile court's attention that certain children might be mentally ill, and the court has processed the children through the regional hospitals for evaluation. However, there have been few, if any, cases filed in which the petition was based solely on an allegation that the child was mentally ill. In fact, it has been my experience that when it has appeared to the court that the child was mentally ill, the court has often directed the child's parents to simply take the child to a proper facility and to have the child admitted for treatment. The court has not sought to create an adversarial situation when a child is in need of mental health treatment and this has been avoided by simply directing the parent to take the child to a facility where proper treatment can be had.

10.

It is also my opinion that the juvenile court system is not equipped to deal with cases where the only allegation made in a petition is that the child is mentally ill.

Our court personnel are trained to handle delinquent and unruly children, but do not have any special training which would allow them to deal with children who are not normal in their responses to directions, rules and instructions necessary in running a detentional [5] facility. Further, this Court's facilities will not allow us to efficiently segregate the mentally ill children from the other children detained by the court, with the resulting possibility of harm to both groups of children. Finally, the court may be further burdened in that the courts personnel, pursuant to Ga. Code § 24A-2101, may be required in some cases, to make independent investigations into the allegations set forth to the court, and the court does not have sufficient personnel to even do this. Hence, I cannot even conclude that Fulton County at present has the facilities and the personnel to properly care for children who are brought to us by their parents seeking treatment for their mentally ill children.

11.

While the impact of the decision on my court is significant, the decision will cause even more difficulties in less urban counties. While the metropolitan counties have a fairly well-developed juvenile court system, the same is not necessarily true in the other counties throughout the State. In most of the counties the superior court judge acts as judge of the juvenile court. This is important because some superior court judges are required to sit in the various counties in their circuit, which means that they may or may not be in the county in which they are the juvenile court judge when a child needs hospitalization. Let me demonstrate this problem by using the Oconee Judicial Circuit which consists of six counties, Bleckley, Dodge, Montgomery, Pulaski, Telfair and

Wheeler and which has only one judge. Under the Juvenile Code as it is presently written, a juvenile must be brought before the juvenile court which is located in the county of his residence. Liberally interpreting this, it means that he must be brought at the minimum before the judge of the juvenile court of his county. However, if the judge for the Oconee Judicial Circuit is holding court in [6] Hawkinsville, the county seat of Pulaski County, and a child who is located in Wheeler County needs medical treatment, it would be necessary, if the child is taken into custody, to transport the child as much as 50 or 60 miles one way to the superior court judge, unless the child's appearance is waived. Further, as the federal court should well know, the superior court judges sit in the counties for various periods of time depending on their calendar. Because of the ten-day limitation contained in the Juvenile Code, it may be necessary to transport that same child from Wheeler County or wherever he is detained together with all of the witnesses and other evidence pertaining to his mental illness to Hawkinsville a second time in order to have a required formal adjudicatory hearing. Alternatively, it may be necessary to move the court, including the judge, the attorneys, the court reporter and the other court personnel to the child, which would be equally burdensome. In short, in counties which are not as fortunate as Fulton County, it may be necesary to transport both the children, who of course are alleged to be mentally ill, as well as the mental health personnel and other witnesses and evidence great distances in order to get the hearing which the federal court's order and the Juvenile Code will require, all of which could only be to the detriment of the mentally ill child who is in need of treatment.

12.

I wish the federal court to know that I do agree that we need some procedure to protect the children in mental health facilities from being abandoned by their parents, but I perceive that the Juvenile Code, if properly used, provides this safeguard since petitions alleging abandonment or other deprivation can be filed by any person at any time. To require, instead, that every child be brought before a juvenile court has ramifications which are far more serious than may appear at first. Adversarial [7] hearings in the juvenile courts are often emotionally traumatic. Placing a parent and a child in an adversarial situation when in fact they do not wish to be adversaries, and when in fact the parent is only seeking the best for his child, would, in my opinion, harm the family relationship. As I noted, I will be required to appoint guardians ad litem for each child alleged to be mentally ill, and it will presumably be that it will be counsel's job to insure that the parents are not acting adversely to the child's best interest. This will require the child's parents to prove, in court, that the child is in fact mentally ill. It is my opinion that when faced with this choice, there are going to be a great number of parents who simply choose not to seek the proper treatment for their children. As a result, the children are going to suffer, and by the time the problem is discovered because the child commits an act of delinquency, or takes some other action which brings him to the juvenile court's attention, the harm will be done. Any action which discourages a parent from seeking the proper care for his child should be avoided.

13.

Finally, I would note that it is my opinion that the court's opinion is going to most adversely affect poor

people. When faced with the prospect of going to the juvenile court and having an adjudicatory hearing in which their child is to be declared mentally ill, those persons who have the means to do so will undoubtedly simply resort to private mental health facilities. Unfortunately this answer is not available to persons who are poor. They have no place to go other than the state supported hospitals, and as a result, it is the children of the poor people who will be deprived of the proper care and treatment. Any other or decision which will have an adverse impact on an economically disadvantaged group should be avoided.

[8]

14.

Therefore, in sum, it is my opinion that the requirements of the judicial intervention be sought every time a parent or guardian seeks to place a child in a mental health care facility will:

(1) Add to the already overburdened dockets of the court system; and

(2) Create many extreme problems with respect to the swift, speedy and fair administration of justice of the juvenile court system; and

(3) Create an unreasonably emotionally traumatic situation, particularly in those cases where a parent is genuinely concerned with the child's welfare and is only trying to seek the best assistance possible for the child; and

(4) Cause many parents to refrain from taking the necessary action to obtain mental health care and treatment needed by the children; and

(5) Have a disproportionate effect on economically disadvantaged persons throughout the State.

/s/ ROMAE T. POWELL
ROMAE T. POWELL
Judge

Sworn to and subscribed
before me this 8th
day of March, 1976.

/s/ ANNE S. DAVIS
Notary Public

Notary Public, Georgia, State at Large
My Commission Expires July 29, 1978

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

AFFIDAVIT

Personally appeared before me the undersigned officer, a person duly authorized to administer oaths, Dennis F. Jones, who states on oath as follows:

1.

I am Dennis F. Jones and I am and have been one of the Juvenile Court Judges for the Juvenile Court of De Kalb County. I have been in that position for 3½ years. In addition, I am the president of the Council of Juvenile Court Judges, of Georgia established by Ga. Code § 24A-501. In my capacity as a Juvenile Court Judge and as president of the Council of Juvenile Court Judges, I have personal knowledge of the matters set forth in this affidavit, and the requisite experience and knowledge to support my opinions which are stated herein. I make this affidavit for use by the defendants in the above-styled action, particularly in support of the application to stay the order of this Court and any judgment thereon pending disposition of the defendants' appeal.

2.

I have examined the order of the federal court entered in the above-styled matter on February 26, 1976. For a number of reasons, including those which are set forth in

detail below, that order will cause and impose a further burden on what is [2] already an overworked, overburdened juvenile court system and will serve to impede the fair, speedy and equitable administration of justice in the juvenile matters.

3.

Initially, there are presently two juvenile court judges who sit in DeKalb County. At the present time, because of the caseload involved in serious matters such as delinquency petitions as well as those situations where a child is truly deprived of parental assistance and guidance, we are able to only hear approximately thirty-five percent of the cases which are filed in our court.

4.

The federal court's order is going to add to this caseload and therefore diminish the juvenile courts' ability to address those cases where a child is actually in need of the court's services.

5.

Further, this problem of the increased caseload will be compounded in that it is apparent that most admissions to the mental health facilities which are sought by parents will be in the nature of an emergency and it will not be feasible to file a petition in the juvenile court prior to taking the child into detention, and this will necessitate at least two hearings for each child sought to be hospitalized by his parents.

6.

This will occur because the law provides that whenever a child is taken into custody and placed in an emergency

detention facility, an informal hearing must be held by the juvenile court within 72 hours.

[3]

7.

After the child has been taken into detention, the law requires that a full, formal adjudicatory hearing take place within ten days. This is important, because it impacts most heavily on the administration of the juvenile court system. Presently, our calendars can be arranged, that is, a delinquent child who is brought before the court can in most instances be released from detention into the custody of his parents or some other responsible adult, thus obviating a necessity of the full adjudicatory hearing within ten days. This allows us to arrange our calendars with some semblance of order. However, with those children who are picked up and placed in the mental hospitals, it would be mandatory that a hearing be held within the ten days following the taking of the child into custody. The court is allowed little leeway in this matter and thus, it would be necessary that we adjust our calendars and schedules to accommodate hearings of these children who have been placed in the mental hospitals.

8.

Additionally, there is the cost of engaging in these types of hearings which has not been budgeted and is not included in the court's appropriation. As I perceive the requirements of the Juvenile Code, and the federal court's order, in every instance where the parents seek to have the child placed in a mental health facility, the court would have to treat the proceeding as an adversarial hearing, with the parents on one side and the child on the other. This will necessitate the appointing of a guardian ad litem in each instance. For private attorneys in

this county, we pay a maximum of $150 for each juvenile court hearing. Of course, the juvenile court law requires that every hearing be [4] recorded, unless waived, which adds additional cost and we require that other court personnel also be involved in these hearings.

9.

Further, the adjudicatory hearing in the juvenile court requires the presentation of evidence on the matters asserted. This will necessitate the appearance in court of the mental health personnel who have the expertise to advise a court in the proper disposition of a case. Obviously, if the personnel of the mental health facility are spending time appearing in court, the time during which they may direct their efforts in more beneficial matters such as caring for the children is diminished.

10.

The federal court's order raises additional problems. In the past, it has been brought to the juvenile court's attention that certain children might be mentally ill, and the court has processed children through the regional hospitals for evaluation. However, in my memory, there have been extremely few actions filed solely on the basis of the child's mental illness. I raise this issue because the court does not have the proper facilities in which to detain these children. The other children which have been brought before the court have been alleged to be delinquent or deprived or unruly and thus have been maintained in the regular court facilities. However, under the federal court's order, the children involved will be children whose parents or guardians feel are mentally ill. At present I do not have the proper facilities, and particularly the personnel who would be trained to handle mentally ill children. That is, our personnel have been trained in handling delinquent and unruly children but do not have any special training which would allow them to deal with children who are not normal in their responses to directions, rules and [5] instructions necessary in running a detentional facility. Hence, I cannot conclude that these children can be properly cared for in our court at the present time.

11.

While the impact of the decision on my court is significant, the decision will cause even more difficulties in the less urban counties. While the metropolitan counties have a fairly well developed juvenile court system, the same is not necessarily true of the other counties throughout the State. In fact, there are only approximately thirty-five counties which have regularly appointed juvenile court judges. In the remaining 124 counties, the superior court judge sits as juvenile court judge and must handle the juvenile court cases in addition to all his other duties. The impact of this is, of course, obvious. While the juvenile courts in the metropolitan counties were specifically established for juveniles, the superior courts throughout the State are not. If the DeKalb County Juvenile Court does not have the proper facilities and the wherewithal to handle children whose only offense is that they are allegedly mentally ill, it is obvious that in other counties in which the superior court must act as the juvenile court, there will not be even the inadequate facilities which exist in DeKalb County.

12.

It is important to note that I do not object to the concept of preventing situations where children are "dumped" in mental hospitals. However, it seems obvious, to use a

well worn phrase, that the cure here might be worse than the illness. It is my opinion, as I have previously stated, that the proceedings re-[6]quired by the federal court order to take place in my court, will have to be maintained as an adversarial proceeding, in that I will have to appoint counsel for each of these children and presumably, it would be the counsel's task to insure that the parents are not acting contrary to the best interests of the child. It has been my experience that the proceedings in the juvenile court system are often emotionally traumatic when the persons are placed in adversarial positions. Placing a parent and a child in an adversarial situation when in fact they do not wish to be adversaries, and when in fact the parent is only seeking best for his child, would, in my opinion, harm the family relationship. While recognizing that a problem may exist in this area, it is my opinion that there is no need to force a parent and child into an adversarial situation in which they do not wish to be, a situation which might well result in the worsening of the child's condition, or cause the parent to refrain from seeking the help the child needs. While it is agreed that a very few children might be "dumped" by their parents, there are other methods that can provide judicial protection against abandonment of children through long term commitments which would not necessarily cause the emotional trauma or the imposition on the family relationship as will the adjudicatory hearing which is being required by this court's order.

13.

Therefore, in sum, it is my opinion that the requirements that judicial intervention be sought every time a parent or guardian seeks to place a child in a mental health care facility will:

[7]

(1) Add to the already overburdened dockets of the juvenile court system;

(2) Create many extreme problems with respect to the swift, speedy and fair administration of justice of the juvenile court system; and

(3) Impose an emotionally traumatic situation, particularly in those cases where the parent is genuinely concerned with the child's welfare and is only trying to seek the best assistance possible for the child.

(4) Cause many parents to refrain from taking the necessary action to obtain mental health care and treatment needed by their children.

(5) Cause the psychiatrists, psychologists, and other mental health people to spend much of their valuable time in courts rather than in treating the children.

/s/ DENNIS F. JONES

DENNIS F. JONES
Judge
Juvenile Court of DeKalb County

Sworn to and subscribed
before me this 4th
day of March, 1976.

/s/ R. DOUGLAS LACKEY
Notary Public

Nov. 3, 1978

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(TITLE OMITTED IN PRINTING)

OPINION OF THE DISTRICT COURT

(Opinion of the district court constitutes Appendix "A" to the Appellants' Jurisdictional Statement)

[1]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

[Filed at 1:00 P.M. Mar. 11, 1976, Walter F. Doyle, Clerk, U.S. District Court]

JUDGMENT PURSUANT TO RULE 54(b), FEDERAL RULES OF CIVIL PROCEDURE

A district court of three judges having rendered its decision on February 26, 1976, as to all matters required to be decided and heard by a court of three judges and having dissolved itself, this constitutes an express determination by the court that there is no just reason for delay of entry of judgment as to all matters required to be heard by a district court of three judges and an express direction for the entry of said judgment. Rule 54(b), Federal Rules of Civil Procedure.

In the manner set forth in the remedial portion of said February 26, 1976, decision which begins on page 42 and continues through page 45, judgment is therefore rendered for the plaintiffs [2] individually and as representatives of the plaintiff class and against the defendants: JAMES PARHAM, individually and as Commissioner of the Department of Human Resources, DOUGLAS SKELTON, individually and as Director of the Division of Mental Health, and W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital.

Judgment pursuant to Rule 54, Federal Rules of Civil Procedure, is expressly not entered as to those portions of said February 26, 1976, order (a) by which a single district judge court continues to have jurisdiction of every child who is a member of the plaintiff class for the pur-

poses stated on pages 43 and 44, and (b) directing the parties to appear on April 21, 1976, before a single district judge to then report in full on all efforts made to effect this order at which time further orders needed to clarify or make explicit said remedial order may be passed by a single district judge.

This 11th day of March, 1976.

/s/ WALTER F. DOYLE
WALTER F. DOYLE, Clerk
United States District Court

Entry directed by and
form approved by

/s/ WILBUR D. OWENS, JR.
WILBUR D. OWENS, JR.
United States District Judge

[1]

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

(Caption omitted in printing)

[Filed at 4:00 P.M. Mar. 17, 1976, Walter F. Doyle, Clerk, U.S. District Court]

Defendants Parham, Skelton and Smith, individually and as officials of the Department of Human Resources of the State of Georgia, have moved this district court of three judges[1] to stay its entire order of February 26, 1976, and the judgment entered March 11, 1976, pending their appeal to the Supreme Court of the United States. For grounds they urge:

> "1. A stay is necessary in order to maintain the status quo and to prevent the issues from becoming moot during the appeal.

[2]

> "2. A stay is necessary in order to protect the public interest during the appeal of the court's order.
>
> "3. A stay is necessary in order to prevent irreparable injury to the members of the plaintiff class during the appeal of the court's decision."

Defendants' motion filed on March 10, 1976, was heard on March 11, 1976. Evidence presented and arguments read and heard having been considered, this constitutes the court's order on defendants' motion.

[1] This court as originally constituted consisted of Circuit Judge Bell, Senior District Judge Bootle and District Judge Owens. Following the court's decision of February 26, 1976, Circuit Judge Bell's resignation became effective on March 1, 1976. Upon notification of the intention of the defendants to [2] file its motion the court was reconstituted by Chief Judge Brown to consist of Circuit Judge Morgan, Senior District Judge Bootle and District Judge Owens.

The defendants by brief and in argument suggest that they satisfy the four criteria which traditionally are considered by trial courts in deciding whether or not to grant a stay pending appeal, to wit: "(1) the applicant must establish a strong likelihood of success on the merits; (2) the applicant must show that he will be irreparably harmed if the stay is not granted; (3) the applicant must show that the other party will not be irreparably harmed by a stay; and (4) the applicant must show that the public interest will be served by the stay." Defendants' brief in support of motion.

The defendants first concede the obvious—this district court of three judges would not have unanimously decided that children cannot be voluntarily committed and detained in Georgia's mental hospitals pursuant to this statute which contains absolutely no due process protection, if it were of the opinion that on appeal the defendants are likely to convince a majority of the Supreme Court to hold to the contrary. Having so conceded, defendants suggest that nevertheless this is a new, novel issue similar to Kremens v. Bartley, 402 F.Supp. 1039 (E.D. Pa. 1975), which was stayed by the Supreme Court on December 15, 1975, and that said stay is a signal that they may indeed prevail upon appeal.

The court secured a copy of the motion for a stay in Kremens as considered and granted by the Supreme Court and again read the decision that was being appealed. Kremens it is first noted, con-[3]siders whether or not a statutory procedure and regulations pertaining thereto which collectively contain some due process type protection for children, described in the dissent of Judge Broderick as follows:

"Under the Pennsylvania Act and regulations, ap-

plication for voluntary admission or commitment to a facility may be made by a parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years or younger. In order to be admitted or committed to an institution, any person aged 18 and younger must first be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency. Such referral must be accomplished by a psychiatric evaluation and a report which states with specificity the reasons that the child requires institutional care. After such referral, the director of the facility to which the parents seek to have their child admitted must then conduct an independent examination of the child in order to determine whether the child is in need of institutional care or observation. If the director's independent examination disagrees with the referring professional's opinion, the child cannot be institutionalized. In the case of a voluntary commitment under §403 of the Act, an acceptance for commitment may not exceed thirty days without a successive application for continued voluntary commitment for an additional thirty day period. In the case of juveniles 13 years of age and older, within 24 hours of admission to the institution, the juvenile must be given written notification which he signs and which is to be fully explained to him and which states that he will be furnished with counsel to represent him. Should a juvenile who is 13 years of age or older object, either orally or in writing, to remaining in the institution, the director, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days, during which time notification shall be made to the applicant and the referral unit so that either party may institute a §406 proceeding, which is the statutorily required court hearing for an involuntary commitment. During that same two day period, the director must obtain counsel to represent the juvenile. The juvenile's counsel is then

furnished with the evaluation of the juvenile by the referral unit, a psychiatric evaluation from the institution, and a written report of the reasons that the institution feels that institutionalization is required.

"The effect of the Act and the regulations promulgated thereunder is that two independent medical opinions must concur in a recommendation of institutionalization before a minor can be voluntarily admitted. In the case of juveniles 13 and over, upon their objections to remaining in the institution, future institutionalization must proceed pursuant to the civil court commitment provisions of the Act. (Section 406). Section 406 provides the procedure for an involuntary civil court commitment and requires the filing of a petition with the Court of Common Pleas, pursuant to which the Court issues a [4] warrant requiring the allegedly ill person to be brought to Court for a hearing. Counsel appointed for the juvenile represents him at the hearing before the Court of Common Pleas. After the hearing, the Court may order an examination by two physicians or order commitment for a period not to exceed ten days for an examination, after which commitment may be ordered by the Court. Plaintiffs do not attack the constitutionality of the civil court commitments under §406 of the Act which follow the above outlined procedure." (footnotes omitted). Kremens, supra, dissent of Judge Broderick, pp. 2-5.

meets due process requirements. The Kremens court decided that these protections are constitutionally inadequate and went further to decide in minute detail what protections are required. Having spelled out every detail the court as to thousands of children in both mental health and mental retardation facilities in Pennsylvania gave the defendants 120 days to initiate and complete recommitment or discharge procedures. Unlike Kremens the decision of this court is only that some due process

protection is required for children to be voluntarily committed to a mental hospital. Unlike Kremens this court's order requires that as to only those 154 children (Dr. Skelton's affidavit in support of motion) who were in defendants' custody on January 31, 1976, proceedings be just commenced—not commenced and completed—in one of Georgia's 159 juvenile courts or one of Georgia's 159 courts of Ordinary within 60 days from the court's order of February 26, 1976. In chambers on January 8, 1976, the defendants were advised that the court's order would allow this 60 day period so in reality they have had an additional 48 days within which to commence such proceedings. Since Georgia's juvenile court system in fiscal year 1974 disposed of 48,116[2] juvenile cases, 154 additional cases scattered throughout this entire state and commenced over a sixty day period should not create an extraordinary problem for the fine juvenile court system that we have in this state. That Kremens and its particular facts demonstrated a crying need for a stay, does not in any way indicate a similar crying need in this case the facts of which are totally different.

[5]

To demonstrate irreparable harm to the defendants they assert that while they as state officials will not be harmed, the people who are served by the State's mental health program will be harmed by the monetary cuts that will have to be made in some services to fund the creation and operation of non-hospital facilities ordered by the court. As the Supreme Court of Georgia reminded all state officials on December 4, 1975, in the case of Busbee v. Georgia Conference, American Association of Univer-

[2] Second Annual Report, Administrative Office of the Courts of Georgia.

sity Professors, 235 Ga. 752, ___ S.E.2d ___ (1975), even the failure of the legislature of this state to appropriate money for a particular purpose does not lessen the legal obligation of state officials to perform their lawful duties using money available for other purposes.

While the defendants did confer with the governor and legislative leaders in January 1976 in response to the court's request that they do so and while Dr. Skelton's affidavit shows that they then said funds were unavailable because they among other things, were of the "opinion that the regional hospitals were offering appropriate treatment for children" (February 26 Order at 18), it now appears that the defendants between February 26, 1976, and the adoption of a final budget about a week later did not request the legislature or the governor to appropriate money to cure and correct the admitted in appropriate treatment of a large number of plaintiff children. Defendants say to even make such a request would be a futile effort. Until such time as each representative and senator and the governor of this state—all fathers and grandfathers like the judges of this court—have been told of the facts of this case and presented with a formal request for such funds and until such time as they have formally denied such funds, this court will not accept defendants' contention that it would be futile to make such a request. Having elected to refrain from communicating with the legislature, defendant state officials can decide[3] for themselves how to go about shifting funds to comply with the court's order.

[3] The defendants are reminded that the Supreme Court declined to hear the plea they are now making in Department of Human Resources v. Burnham, 43 U.S.L.W. [6] 3683 (U.S. June 30, 1975) (No. 74-904), *denying cert. to* 503 F.2d 1319 (5th Cir.). In that case, one of the questions presented in the petition for certiorari was:

> "Can federal district court, consistent with Eleventh Amendment, entertain suit by private individuals that would require state to re-order its priorities and increase its level of fiscal support for therapeutic or curative psychiatric treatment it provides in its mental institutions?"

43 U.S.L.W. 3459 (U.S. Feb. 18, 1975) (No. 75-904).

[6]

While they steadfastly refuse to so admit, their failure to request funds could be due to their agreement with this court's opinion that the creation and operation of appropriate non-hospital facilities for these children in reality will save rather than cost money, i.e. hospital care costs some $40,000 per year per child whereas group home care costs some $7,500 per year per child; residential treatment care centers cost $12,000 per year per child.

As the evidence shows, the defendants agree that less stringent, non-hospital facilities are needed and are more appropriate but they want to provide them when they deem it advisable to do so, not when this court orders them to do so. To be compelled to do what admittedly should be done is not to be harmed.

Defendants say that plaintiff minor children are being harmed by the court's present order because that order is setting priorities for the Department of Human Resources. "As an alternative to allowing the court to set priorities for the Department, the Department can and will simply relinquish custody of the 46 children to the persons who placed the children with the Department." They would thus be deprived of their present care and treatment. A stay would prevent this harm and permit their present care and treatment to continue. Thus they conclude that a stay would help rather than hurt these children.

Implicit in this court's February 26, 1976, order is the court's considered opinion that every minute of unnecessary or inappropriate confinement and detention of a child in a mental hospital is a deprivation of liberty which affects him adversely and from the harmful effects of which he may never recover. That considered judgment has not changed.

[7]

The defendants go on to say that the public interest will be served by a stay because it is in the public interest to encourage and make it easy to admit children to mental hospitals rather than discouraging their admittance by requiring an adversarial juvenile court hearing. They also say it is in the public interest to not burden Georgia's juvenile court system with mentally ill children.

The evidence shows that in spite of requested permission to do so, defendants between January 8 and February 26, 1976, did not apprise their employees that they were expecting an adverse ruling and that it would soon be necessary to either petition juvenile court or assist parents in petitioning juvenile court to admit children in need of treatment. The confusion that defendants say exists, the reported reluctance of some parents to process their children through juvenile court, results from a total lack of effort on defendants part to prepare their employees to communicate with parents and juvenile courts and to implement the order that they had been told was coming. Any parent who sincerely believes that his child is mentally ill and in need of treatment will not hesitate to have his child civilly committed through juvenile court or any other court process. Proof of this is that according to the defendants 1,111 children were involuntarily court committed during the fiscal years 1969 through 1976. Order of February 26, 1976 at 10.

The legislature of this state after careful study enacted an already described completely revised Juvenile Court Code in 1971. That code provided then and provides now for children who are mentally ill. 1933 Ga. Code Ann. § 24A-301 and 2601. That code contains already mentioned due process safeguards. To begin to utilize this revised juvenile court code for mentally ill children will be only to do in 1976 what the legislature of this state provided to be done beginning in 1971. The total of 22 children defendants estimate will be the subject each month of juvenile court proceedings will be a small addition to the said 48,116 juvenile cases handled on a yearly basis in Georgia's juvenile courts.

[8]

The State is being required to utilize an existing court system and to create non-hospital facilities that they themselves say they need and eventually want. Neither the utilization of juvenile courts nor the creation of such needed, wanted facilities will moot the issues upon appeal because if defendants prevail upon appeal, they will be free to return to the statutory system still deemed by this court to be violative of the Due Process Clause of the Fourteenth Amendment to the Constitution of the United States. Alee v. Medrano, 416 U.S. 802, 811, 40 L.Ed 2d 566, 578, 94 S.Ct. 2191, ——, to wit:

> "It is settled that an action for an injunction does not become moot merely because the conduct complained of has terminated, if there is a possibility of recurrence, since otherwise the defendants 'would be free to return to ". . . [their] old ways." ' Gray v. Sanders, 372 US 368, 376, 9 L Ed 2d 821, 83 S Ct 801; Walling v. Helmerich & Payne, Inc. 323 US 37, 43, 89 L Ed 29, 65 S Ct 11; United States v. W. T. Grant Co. 345 US 629, 632, 97 L Ed 1303, 73 S Ct

894; NLRB v. Raytheon Co., 398 US 25, 27, 26 L Ed 2d 21, 90 S Ct 1547; SEC v. Medical Committee for Human Rights, 404 US 403, 406, 30 L Ed 2d 560, 92 S Ct 577. . . ."

Defendants' arguments presented and considered are essentially a restatement of contentions made before the court issued its February 26, 1976, order. Then and now they have been considered and found wanting.

It is therefore the carefully considered judgment of this court that it is in the best interest of the plaintiff minor children that defendants' motion to stay pending appeal is denied.

IT IS SO ORDERED this 17th day of March, 1976.

/s/ LEWIS R. MORGAN
LEWIS R. MORGAN
United States Circuit Judge

/s/ W. A. BOOTLE
W. A. BOOTLE
Senior United States District Judge

/s/ WILBUR D. OWENS, JR.
WILBUR D. OWENS, JR.
United States District Judge

[1] **IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION**

(Caption omitted in printing)

NOTICE OF APPEAL
TO THE SUPREME COURT
OF THE UNITED STATES

Notice is hereby given that T.M. "Jim" Parham, Douglas Skelton, M.D. and W.T. Smith, defendants above named, individually and in their official capacities, hereby appeal to the Supreme Court of the United States, from the order of this Court entered in this action on the 26th day of February, 1976, and the final judgment entered thereon on the 11th day of March, 1976.

This appeal is taken pursuant to 28 U.S.C. § 1253.

This 24th day of March, 1976.

ARTHUR K. BOLTON
Attorney General

ROBERT S. STUBBS, II
Chief Deputy Attorney General

/s/ DON A. LANGHAM
DON A. LANGHAM
Deputy Attorney General

/s/ TIMOTHY J. SWEENEY
TIMOTHY J. SWEENEY
Senior Assistant Attorney General

/s/ R. DOUGLAS LACKEY
R. DOUGLAS LACKEY
Assistant Attorney General

Please Serve:

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SUPREME COURT OF THE UNITED STATES

[Filed at 9:30 A.M., Jun. 6, 1977, G. W. Hawkins, Deputy Clerk, U.S. District Court, MIDDLE DISTRICT OF GEORGIA]

No. 75-1690

JAMES PARHAM, individually and as Commissioner of Department of Human Resources, et al.,

Appellants,

v.

J. L. and J. R., minors, etc.

APPEAL from the United States District Court for the Middle District of Georgia.

The statement of jurisdiction in this case having been submitted and considered by the Court, probable jurisdiction is noted. In addition to the questions presented by the jurisdictional statement the parties are directed to brief and argue the following question:

"Whether, where the parents of a minor voluntarily place the minor in a state institution, there is sufficient 'state action,' including subsequent action by the state institution, to implicate the Due Process Clause of the Fourteenth Amendment?"

May 31, 1977

A true copy MICHAEL RODAK, JR.
Test:

Clerk of the Supreme Court of the United States

BY /s/ LAWRENCE P. GILL
Deputy

CERTIFICATE OF SERVICE

I, R. Douglas Lackey, one of the attorneys for the Appellants herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served opposing counsel in this action with three copies of the foregoing Appendix, by depositing three copies of the same in the United States mail, with first class postage prepaid, addressed as follows:

Joseph J. Levin, Jr.
Counsel for Appellees
Southern Poverty Law Center
1001 South Hull Street
Montgomery, Alabama 36101

This ____ day of August, 1977.

R. DOUGLAS LACKEY
Assistant Attorney General

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Divison of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. AND J. R., Minors, individually and as representatives of a class of persons similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

MOTION FOR PLENARY REVIEW OR IN THE ALTERNATIVE TO AFFIRM

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June, 1976

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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. AND J. R., Minors, individually and as representatives of a class of persons similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE MIDDLE
DISTRICT OF GEORGIA

MOTION FOR PLENARY REVIEW OR
IN THE ALTERNATIVE TO AFFIRM

Appellees, pursuant to Rule 35 of the Rules of the Supreme Court, move this court to grant plenary review of this case.

In the alternative, appellees, pursuant to Rule 16 of the Rules of the Supreme Court, move that final judgment and decree of the District Court be affirmed on the ground that the question is so clearly correct as not to warrant further argument.

OPINION BELOW

The opinion and judgment of the District Court

is not yet reported. A copy is contained in Jurisdictional Statement, Appendix A, and Appendix B respectively.[1/]

The order of the District Court denying appellants' motion to stay is not yet reported. A copy is attached as Appendix A to this Motion.

JURISDICTION

The jurisdictional requisites are adequately set forth in the Jurisdictional Statement.

QUESTIONS PRESENTED

1. Whether a statute which permits parents or guardians to place children in state mental institutions without any prior procedural safeguards for an indeterminate period of time, is violative of the Due Process clause of the Fourteenth Amendment, and is therefore unconstitutional.

2. Whether a statute which allows the state upon application of a parent or guardian to admit and detain a child in a state mental institution for an indefinite period of time without any procedure for initial and periodic consideration of the necessity of confinement is violative of the Due Process clause of the Fourteenth Amendment, and is therefore unconstitutional.

STATEMENT

Two minors, J. L. and J. R., filed a class action on October 24, 1975, requesting the U. S. District

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[1/] Since the opinion is not reported, all references in this motion will be to page numbers of the Appendix to the Jurisdictional Statement and will be cited as J.S.A.

Court to declare unconstitutional Acts 1969, pp. 505, 517, informally codified as Ga. Code Ann. 88-503.1(a), as being in violation of the Due Process clause of the Fourteenth Amendment and to enjoin its enforcement.

A parent or guardian, pursuant to 88-503.1(a), can place a child in a state mental health facility for observation and diagnosis for an unlimited period of time. If found to have evidence of mental illness and to be suitable for treatment, formal detention can exist for an indefinite period of time. J. L. and J. R. had each been detained in excess of five years. Children placed in this fashion are designated as "voluntary" patients by the statute.

Plaintiffs urged that their constitutional rights to due process were violated by their commitment to and indefinite confinement in state mental institutions (1) without any prior meaningful and complete opportunity to be heard and (2) without initial and periodic review of the necessity of confinement.

On November 15, 1975, a three judge court was convened pursuant to 28 U.S.C. 2281, 2284, and heard oral argument on the legal issues. Oral testimony was taken by deposition of 23 expert and lay witnesses. The court visited two state mental institutions and reviewed extensive exhibits.

On February 26, 1976, the court issued its unanimous opinion. The opinion found that applications for hospital admission are in practice made either by parents or county welfare departments as guardians. J.S.A. at 39a. Despite the good intentions of many parents,

others utilize the procedure to abandon their children, treating mental hospitals as "dumping grounds." J.S.A. at 40a, 50a.

The observation stage of the admission process results in children being confined or placed in a hospital behind locked doors. J.S.A. at 41. The physician who decides upon detention is subject to error and must utilize a standard "as indefinite and elusive to the psychiatrist... as it is to the layman." J.S.A. at 53a, 42a-43a.

In practice the minor child once committed can be released only if the hospital and parent or guardian agree. Due to the absence of alternative placements, a Superintendent cannot release a child without willing and able parents; the absence of parents ready to "accept their child is unfortunately a normal situation." J.S.A. at 44a-45a. The state admits there are minors in the hospital who do not need to be there. J.S.A. at 44a-45a.

The state was made aware of these conditions by a study commission in 1973, but has failed to take any action. J.S.A. at 52a.

The District Court noted that the liberty interest of juveniles in the context of these facts was strikingly similar to the losses sustained by a juvenile in a delinquency proceeding. J.S.A. at 48a. The court found that the Due Process clause was applicable to confinement and detention under the statute.

The court did not prescribe those elements of due process necessary under the Fourteenth Amendment. Rather the defendants were required to either utilize

existing state procedures containing procedural safeguards or to release the members of the class.

Similarly the Court ordered the defendants to "proceed as expeditiously as is reasonably possible" to provide non-hospital resources deemed by defendants most appropriate and to place a specified and limited identifiable subgroup in a non-hospital setting as "soon as reasonably appropriate." J.S.A. at 54a.[2/]

The statute was declared unconstitutional and its enforcement enjoined.

REASONS FOR PLENARY REVIEW

The issues presented in this case are similar to those already before this Court. Kremens v. Bartley, prob. juris. noted, 44 U.S.L.W. 3525 (1976). Although both district courts have held due process applicable to the "voluntary" commitment of juveniles to mental institutions, the similarity ends there.

In Bartley v. Kremens, 402 F. Supp. 1039 (E.D. Pa. 1975) the District Court found that a state statute and regulations providing limited safeguards failed to meet the constitutional standard of the Due Process clause of the Fourteenth Amendment. The District Court specified in detail the procedural elements necessary to commit juveniles.

[2/] The term "optimally appropriate treatment setting" is the appellants characterization initially expressed in a letter to the court. J.S.A. at 21a. The District Court did not adopt this language and it appears nowhere else in the opinion.

The case at bar is different in several respects. First, no due process procedures of any kind existed. J.S.A. at 46a-47a. Second, all children up to age 18 were confined and detained without resort to any meaningful hearing. J.S.A. at 53a.

Finally, the District Court noted the existence of two other systems (juvenile courts and courts of Ordinary) which do provide procedural protections and through which the state could accomplish the same purpose it sought to achieve in the constitutionally deficient statute.

Specifically the court found some due process was required. Appendix at 4a. A careful analysis of existing juvenile and mental health statutes established that procedural rights to notice, hearing, counsel and an impartial tribunal were present. J.S.A. at 33a-38a. Post-commitment hearings were limited to non-emergency cases, and special provision was made for emergency detention. All juveniles were treated equally. Furthermore, these protections were previously established by the legislature and not created by the court.

Thus the court found the challenged statute supplied not the flexible due process the situation demanded, but instead absolutely no due process. J.S.A. at 53a. It then required the state to utilize its own pre-existing court systems which did provide adequate due process protections for children in plaintiffs' class.

> [T]o begin to utilize this revised juvenile court code for mentally ill children will be only to do in 1976 what the legislature of this state provided to be done beginning in 1971. Appendix at 7a.

That probable jurisdiction was noted in Kremens

evidences the importance of the question presented there and in this case. The significance of the marked difference between the cases enumerated above warrants the granting of plenary review in this case.

ARGUMENT TO AFFIRM

The Georgia statute results in the commitment of minors below 18 to state mental institutions upon application of their parents or guardians. There are no meaningful procedures to determine if the alleged mentally ill minor in fact requires commitment. Confinement is indefinite. Release questionable. J.S.A. at 46a.

Although these issues are substantial, Kremens v. Bartley, prob. juris. noted, 44 U.S.L.W. 3525 (1976), the determination that due process safeguards are applicable to this restraint of liberty is so clearly correct as to require summary affirmance.

The involuntary commitment of an individual cannot be accomplished by the state without due process of law. O'Connor v. Donaldson, ___U.S.___, 95 S.Ct. 2486, ____, 45 L.Ed.2d 396, 410 (1975), citing Specht v. Patterson, 386 U.S. 605, 608 (1967), and Application of Gault, 387 U.S. 1, 12-13 (1967). This court has consistently required due process requirements to protect the constitutional rights of those whose liberty is threatened in this manner. Baxstrom v. Herold, 383 U.S. 107 (1966); Jackson v. Indiana, 406 U.S. 715 (1972); Humphrey v. Cady, 405 U.S. 504 (1972).

The protection of liberty accorded by the Fourteenth Amendment is applicable to children as well as adults. Application of Gault, 387 U.S. 1, 13 (1967);

Kent v. United States, 388 U.S. 541 (1966); Haley v. Ohio, 332 U.S. 596 (1948).

The denomination of the action taken as civil or criminal, voluntary or involuntary cannot be used to bypass the protection accorded the juvenile. See: Specht v. Patterson, 386 U.S. 605 (1967). Rather a court must eschew the label of convenience attached by the state so the commitment process can be candidly appraised. Breed v. Jones, 421 U.S. 519, 529 (1975) citing Application of Gault, supra, at 50 and In re Winship, 397 U.S. 358, 365-366 (1970).

Similarly the alleged purpose for the restriction of liberty, be it rehabilitation or treatment, cannot be utilized to justify a scheme devoid of due process. Application of Gault, supra, at 21.

The specific safeguards required by the Due Process clause are determined by a balancing of the interest at stake, but at a minimum include notice and hearing. Powell v. Alabama, 287 U.S. 45 (1932). The Georgia legislature has determined what procedures apply to mental commitment and the commitment of juveniles in particular. Ga. Code Ann., Titles 88-5 and 24A. The court found these procedures provide the minimal safeguards not present in the challenged statute. J.S.A. at 33(a)-38(a). The opinion requires nothing more than that which the state already utilizes. It simply foreclosed an unconstitutional procedure. Such a ruling is clearly correct.

The government may interfere with the lives of its citizens if its purpose is substantially legitimate. However, it cannot use such broad means of interference so as to "stifle fundamental liberties when its ends can

be more narrowly achieved." Shelton v. Tucker, 369 U.S. 479, 488 (1960).

The civil commitment of an individual involves a massive curtailment of liberty. Humphrey v. Cady, 405 U.S. 504, 509 (1972); O'Connor v. Donaldson, ___U.S.___, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975). This infringement is magnified in the case of a child. It can result in social ostracism, In re Ballay, 482 F.2d 648, 667-69 (D.C. Cir. 1973), and severe emotional and psychic harm. Matthews v. Hardy, 420 F.2d 607, 611 (D.C. Cir. 1969).

> [D]ue Process requires the nature and duration of the commitment bear some reasonable relation to the purpose for which the individual is committed. Jackson v. Indiana, 406 U.S. 715, 738 (1972); See Application of Gault, supra, at 27, 28 n. 41.

This principle of the "least restrictive alternative" is applicable to civil commitment of the mentally ill. Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966); Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Lessard v. Schmidt, 349 F.Supp. 1078 (E.D. Wisc. 1972), vacated and remanded on other grounds, 414 U.S. 473(1974), on remand, 379 F.Supp. 1376 (E.D. Wisc. 1974), vacated and remanded on other grounds, 95 S.Ct. 1943 (1975).

The District Court reached a similar conclusion in the face of overwhelming evidence that the fundamental liberties of children were being broadly stifled with no relation to the purpose of commitment.[3/] J.S.A. at 54a. Such a hold-

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[3/] By the Appellants own admission, 46 children do not require hospitalization. J.S.A. at 54a. This condition has existed for some children for over three years. J.S.A. at 6a.

ing so clearly conforms to existing precedent that it should be summarily affirmed.

Neither is the role of the family diminished by the requirement of due process. The important role accorded to the support of the family and parental control has always been subject to limitation. Reynolds v. United States, 95 U.S. 145 (1878)(polygamy); Prince v. Massachusetts, 321 U.S. 150 (1944); Wisconsin v. Yoder, 406 U.S. 205, 233-234 (1971) (parental power limited "if it appears that parental decisions will jeopardize the health or safety of the child or have a potential for significant social burdens.")

Although this case does not involve the conflict of state and parent/child contained in the above decisions, it is directly in line with their holdings. At issue is the power of the parent and state to indefinitely commit a child to a state institution. Such a decision is clearly one which can jeopardize the health of the child and has potential for significant social burdens. J.S.A. at 46a. No characterization of horrors by the defendants can transcend this well settled principle into an issue conflicting with a decision of this Court.

THERE IS NO CONFLICT AMONG THE COURTS

Despite the great shift in precedent alleged by appellants, there are in fact no cases in conflict with the District Court's opinion. Almost eight years ago the Tenth Circuit Court of Appeals found that the Due Process Clause was applicable in the commitment of a minor to a training school for the epileptic and

feeble minded. Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968). District courts in Tennessee and Wisconsin are also in accord with the holding of this case. Saville v. Treadway, 404 F.Supp. 430 (M.D. Tenn. 1974); Kidd v. Schmidt, ___F.Supp. ___ (E.D. Wis., August 15, 1975).

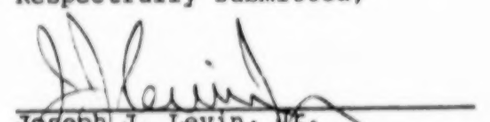
Similar cases are currently pending in federal courts. Poe v. Weinberger, C.A. No. 74-1800(D.D.C.)(Three-Judge Court)(class determined); Campbell v. Director of the Michigan Department of Mental Health, Civ. No. 572318 (E.D. Mich.).

One case is now pending review by this Court. Bartley v. Kremens, 402 F.Supp. 1039 (E.D. Pa. 1975), prob. juris. noted, sub. nom, Kremens v. Bartley, 44 U.S.L.W. 3525 (1976). However, that case is distinguishable from the instant decision. See pp. 5-7 herein and Appendix A.

CONCLUSION

For the foregoing reasons, appellees respectfully move this court to grant plenary review of this case or, in the alternative, to summarily affirm the judgment of the court below.

Respectfully submitted,



Joseph J. Levin, Jr.
COUNSEL OF RECORD FOR APPELLEES

June, 1976.

APPENDIX A

IN THE UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF GEORGIA

MACON DIVISION

Filed at 4:00 P.M.
Mar 17, 1976

/s/ Walter F. Doyle
Clerk, U.S. District Court

J. L. AND J. R., minors, individually and as representatives of a class consisting of all persons younger than 18 years of age, now or hereafter received by any defendant for observation or diagnosis and/or detained for care or treatment at any facility within the State of Georgia, pursuant to 1969 Georgia Laws pp. 505-517, informally codified as Georgia Code Annotated § 88-503.1,	CIVIL ACTION NO. 75-163-MAC
Plaintiffs,	
-v-	
JAMES PARHAM, individually and as Commissioner of the Department of Human Resources, DOUGLAS SKELTON, individually and as Director of the Division of Mental Health and W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital,	
Defendants.	

Defendants Parham, Skelton and Smith, individually and as officials of the Department of Human Resources of the State of Georgia, have moved this district court of three judges[1] to stay its entire order of February 26, 1976, and the judgment entered March 11, 1976, pending their appeal to the Supreme Court of the United States. For grounds they urge:

> 1. A stay is necessary in order to maintain the status quo and to prevent the issues from becoming moot during the appeal.

[1]This court as originally constituted consisted of Circuit Judge Bell, Senior District Judge Bootle and District Judge Owens. Following the court's decision of February 26, 1976, Circuit Judge Bell's resignation became effective on March 1, 1976. Upon notification of the intention of the defendants to file this motion the court was reconstituted by Chief Judge Brown to consist of Circuit Judge Morgan,

[1](Continued) Senior District Judge Bootle and District Judge Owens.

"2. A stay is necessary in order to protect the public interest during the appeal of the court's order.

"3. A stay is necessary in order to prevent irreparable injury to the members of the plaintiff class during the appeal of the court's decision."

Defendants' motion filed on March 10, 1976, was heard on March 11, 1976. Evidence presented and arguments read and heard having been considered, this constitutes the court's order on defendants' motion.

The defendants by brief and in argument suggest that they satisfy the four criteria which traditionally are considered by trial courts in deciding whether or not to grant a stay pending appeal, to wit: "(1) the applicant must establish a strong likelihood of success on the merits; (2) the applicant must show that he will be irreparably harmed if the stay is not granted; (3) the applicant must show that the other party will not be irreparably harmed by a stay; and (4) the applicant must show that the public interest will be served by the stay." Defendants' brief in support of motion.

The defendants first concede the obvious -- this district court of three judges would not have unanimously decided that children cannot be voluntarily committed and detained in Georgia's mental hospitals pursuant to this statue[sic] which contains absolutely no due process protection, if it were of the opinion that on appeal the defendants are likely to convince a majority of the Supreme Court to hold to the contrary. Having so conceded, defendants suggest that nevertheless this is a new, novel issue similar to Kremens v. Bartley, 402 F.Supp. 1039 (E.D. Pa. 1975), which was stayed by the Supreme Court on December 15, 1975, and that said stay is a signal that they may indeed prevail upon appeal.

The court secured a copy of the motion for a stay in Kremens as considered and granted by the Supreme Court and again read the

decision that was being appealed. Kremens it is first noted, considers whether or not a statutory procedure and regulations pertaining thereto which collectively contain some due process type protection for children described in the dissent of Judge Broderick as follows:

> "Under the Pennsylvania Act and regulations, application for voluntary admission or commitment to a facility may be made by a parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years or younger. In order to be admitted or committed to an institution, any person aged 18 and younger must first be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency. Such referral must be accomplished by a psychiatric evaluation and a report which states with specificity the reasons that the child requires institutional care. After such referral, the director of the facility to which the parents seek to have their child admitted must then conduct an independent examination of the child in order to determine whether the child is in need of institutional care or observation. If the director's independent examination disagrees with the referring professional's opinion, the child cannot be institutionalized. In the case of a voluntary commitment under §403 of the Act, an acceptance for commitment may not exceed thirty days without a successive application for continued voluntary commitment for an additional thirty day period. In the case of juveniles 13 years of age and older, within 24 hours of admission to the institution, the juvenile must be given written notification which he signs and which is to be fully explained to him and which states that he will be furnished with counsel to represent him. Should a juvenile who is 13 years of age or older object, either orally or in writing, to remaining in the institution, the director, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days, during which time notification shall be made to the applicant and the referral unit so that either party may institute a §406 proceeding, which is the statutorily required court hearing for an involuntary commitment. During that same two day period, the director must obtain counsel to represent the juvenile. The juvenile's counsel is then furnished with the evaluation of the juvenile by the referral unit, a psychiatric evaluation from the institution, and a written report of the reasons that the institution feels that institutionalization is required.
>
> "The effect of the Act and the regulations pro-

> mulgated thereunder is that two independent medical opinions must concur in a recommendation of institutionalization before a minor can be voluntarily admitted. In the case of juveniles 13 and over, upon their objections to remaining in the institution, future institutionalization must proceed pursuant to the civil court commitment provisions of the Act. (Section 406). Section 406 provides the procedure for an involuntary civil court commitment and requires the filing of a petition with the Court of Common Pleas, pursuant to which the Court issues a warrant requiring the allegedly ill person to be brought to Court for a hearing. Counsel appointed for the juvenile represents him at the hearing before the Court of Common Pleas. After the hearing, the Court may order an examination by two physicians or order commitment for a period not to exceed ten days for an examination, after which commitment may be ordered by the Court. Plaintiffs do not attack the constitutionality of the civil court commitments under §406 of the Act which follow the above outlined procedure." (footnotes omitted). Kremens, supra, dissent of Judge Broderick, pp. 2-5.

meets due process requirements. The Kremens court decided that these protections are constitutionally inadequate and went further to decide in minute detail what protections are required. Having spelled out every detail the court as to thousands of children in both mental health and mental retardation facilities in Pennsylvania gave the defendants 120 days to initiate and complete recommitment or discharge procedures. Unlike Kremens the decision of this court is only that some due process protection is required for children to be voluntarily committed to a mental hospital. Unlike Kremens this court's order requires that as to only those 154 children (Dr. Skelton's affidavit in support of motion) who were in defendants' custody on January 31, 1976, proceedings be just commenced -- not commenced and completed -- in one of Georgia's 159 juvenile courts or one of Georgia's 159 courts of Ordinary within 60 days from the court's order of February 26, 1976. In chambers on January 8, 1976, the defendants were advised that the court's order would allow this 60 day period so in reality they have had an additional 48 days within which to commence such proceedings. Since Georgia's juvenile court system in fiscal year

1974 disposed of 48,116[2] juvenile cases, 154 additional cases scattered throughout this entire state and commenced over a sixty day period should not create an extraordinary problem for the fine juvenile court system that we have in this state. That Kremens and its particular facts demonstrated a crying need for a stay, does not in any way indicate a similar crying need in this case the facts of which are totally different.

To demonstrate irreparable harm to the defendants they assert that while they as state officials will not be harmed, the people who are served by the State's mental health program will be harmed by the monetary cuts that will have to be made in some services to fund the creation and operation of non-hospital facilities ordered by the court. As the Supreme Court of Georgia reminded all state officials on December 4, 1975, in the case of Busbee v. Georgia Conference, American Association of University Professors, 235 Ga. 752, ___S.E.2d___ (1975), even the failure of the legislature of this state to appropriate money for a particular purpose does not lessen the legal obligation of state officials to perform their lawful duties using money available for other purposes.

While the defendants did confer with the governor and legislative leaders in January 1976 in response to the court's request that they do so and while Dr. Skelton's affidavit shows that they then said funds were unavailable because they among other things, were of the "opinion that the regional hospitals were offering appropriate treatment for children" (February 26 Order at 18), it now appears that the defendants between February 26, 1976, and the adoption of a final budget about a week later did not request the legislature or the governor to appropriate money t cure and

[2]Second Annual Report, Administrative Office of the Courts of Georgia

correct the admitted inappropriate treatment of a large number of plaintiff children. Defendants say to even make such a request would be a futile effort. Until such time as each representative and senator and the governor of this state -- all fathers and grandfathers like the judges of this court -- have been told of the facts of this case and presented with a formal request for such funds and until such time as they have formally denied such funds, this court will not accept defendants' contention that it would be futile to make such a request. Having elected to refrain from communicating with the legislature, defendant state officials can decide[3] for themselves how to go about shifting funds to comply with the court's order.

While they steadfastly refuse to so admit, their failure to request funds could be due to their agreement with this court's opinion that the creation and operation of appropriate non-hospital facilities for these children in reality will save rather than cost money, i.e. hospital care costs some $40,000 per year per child whereas group home care costs some $7,500 per year per child; residential treatment care centers cost $12,000 per year per child.

As the evidence shows, the defendants agree that less stringent, non-hospital facilities are needed and are more appropriate but they want to provide them when they deem it advisable to do so, not when this court orders them to do so. To be compelled to do what admittedly should be done is not to be harmed.

Defendants say that plaintiff minor children are being harmed by the court's present order because that order is setting priorities for the Department of Human Resources. "As an alternative to allowing the court to set priorities for the Department

[3]The defendants are reminded that the Supreme Court declined to hear the plea they are now making in Department of Human Resources v. Burnham, 43 U.S.L.W. 3683 (U.S. June 30, 1975)(No. 74-904), denying cert. to 503 F.2d 1319 (5th Cir.). In that case, one of the

[3](Continued) questions presented in the petition for certiorari was:

> "Can federal district court, consistent with Eleventh Amendment, entertain suit by private individuals that would require state to re-order its priorities and increase its level of fiscal support for therapeutic or curative psychiatric treatment it provides in its mental institutions?"

43 U.S.L.W. 3459 (U.S. Feb. 18, 1975)(No. 75-904).

---

the Department can and will simply relinquish custody of the 46 children to the persons who placed the children with the Department." They would thus be deprived of their present care and treatment. A stay would prevent this harm and permit their present care and treatment to continue. Thus they conclude that a stay would help rather than hurt these children.

Implicit in this court's February 26, 1976, order is the court's considered opinion that every minute of unnecessary or inappropriate confinement and detention of a child in a mental hospital is a deprivation of liberty which affects him adversely and from the harmful effects of which he may never recover. That considered judgment has not changed.

The defendants go on to say that the public interest will be served by a stay because it is in the public interest to encourage and make it easy to admit children to mental hospitals rather than discouraging their admittance by requiring an adversarial juvenile court hearing. They also say it is in the public interest to not burden Georgia's juvenile court system with mentally ill children.

The evidence shows that in spite of requested permission to do so, defendants between January 8 and February 26, 1976, did not apprise their employees that they were expecting an adverse ruling and that it would soon be necessary to either petition juvenile court or assist parents in petitioning juvenile court to admit children in need of treatment. The confusion that de-

fendants say exists, the reported reluctance of some parents to process their children through juvenile court, results from a total lack of effort on defendants part to prepare their employees to communicate with parents and juvenile courts and to implement the order that they had been told was coming. Any parent who sincerely believes that his child is mentally ill and in need of treatment will not hesitate to have his child civilly committed through juvenile court or any other court process. Proof of this is that according to the defendants 1,111 children were involuntarily court committed during the fiscal years 1969 through 1976. Order of February 26, 1976 at 10.

The legislature of this state after careful study enacted an already described completely revised Juvenile Court Code in 1971. That code provided then and provides now for children who are mentally ill. 1933 Ga. Code Ann. § 24A-301 and 2601. That code contains already mentioned due process safeguards. To begin to utilize this revised juvenile court code for mentally ill children will be only to do in 1976 what the legislature of this state provided to be done beginning in 1971. The total of 22 children defendants estimate will be the subject each month of juvenile court proceedings will be a small addition to the said 48,116 juvenile cases handled on a yearly basis in Georgia's juvenile courts.

The State is being required to utilize an existing court system and to create non-hospital facilities that they themselves say they need and eventually want. Neither the utilization of juvenile courts nor the creation of such needed, wanted facilities will moot the issues upon appeal because if defendants prevail upon appeal, they will be free to return to the statutory system still deemed by this court to be violative of the Due Process Clause of the Fourteenth Amendment to the

United States. Allee v. Medrano, 416 U.S. 802, 811, 40 L.Ed 2d 566, 578, 94 S.Ct. 2191, ___, to wit:

> "It is settled that an action for an injunction does not become moot merely because the conduct complained of has terminated, if there is a possibility of recurrence, since otherwise the defendants 'would be free to return to ". . . [their] old ways."' Gray v. Sanders, 372 US 368, 376, 9 L Ed 2d 821, 83 S Ct 801; Walling v. Helmerich & Payne, Inc. 323 US 37, 43, 89 L Ed 29, 65 S Ct 11; United States v. W. T. Grant Co. 345 US 629, 632, 97 L Ed 1303, 73 S Ct 894; NLRB v. Raytheon Co., 398 US 25, 27, 26 L Ed 2d 21, 90 S Ct 1547; SEC v. Medical Committee for Human Rights, 404 US 403, 406, 30 L Ed 2d 560, 92 S Ct 577. . . ."

Defendants' arguments presented and considered are essentially a restatement of contentions made before the court issued its February 26, 1976, order. Then and now they have been considered and found wanting.

It is therefore the carefully considered judgment of this court that it is in the best interest of the plaintiff minor children that defendants' motion to stay pending appeal is denied.

IT IS SO ORDERED this 17th day of March, 1976.

/s/ Lewis R. Morgan
Lewis R. Morgan
United States Circuit Judge

/s/ W. A. Bootle
W. A. Bootle
Senior United States District Judge

/s/ Wilbur D. Owens, Jr.
Wilbur D. Owens, Jr.
United States District Judge

Supreme Court, U. S.
FILED
AUG 15 1977
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

October Term, 1975

No. 75-1690

T.M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W.T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J.L. AND J.R., Minors, Individually and as representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

BRIEF FOR APPELLANTS

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IN THE

Supreme Court of the United States

October Term, 1975

No. 75-1690

T.M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W.T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

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Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

BRIEF FOR APPELLANTS

OPINION BELOW

The opinion of the district court is reported at 412 F. Supp. 112. A copy of the opinion is set forth in Appendix A to the Jurisdictional Statement.

JURISDICTION

The decision of the district court was entered February 26, 1976, with final judgment entered thereon on March 11, 1976. A notice of appeal was filed on March 24, 1976 and this Court noted probable jurisdiction on May 31, 1977.

The jurisdiction of this Court is conferred by Title 28, United States Code, Section 1253.

QUESTIONS PRESENTED

I. Whether the Due Process Clause of the Fourteenth Amendment requires parents, or persons standing in their stead, to secure approval, in an adversarial proceeding against their child, prior to securing for that child medically-indicated institutional mental health services afforded by the State?

II. Whether, when the parents of a minor voluntarily place the minor in a State mental health facility, there is sufficient "state action," including subsequent action by the State mental health facility, to implicate the Due Process Clause of the Fourteenth Amendment?

III. Whether, assuming that more than one treatment setting would benefit a mentally ill person under 18 years of age, the Fourteenth Amendment to the Constitution of the United States mandates that the State must, if it is to provide services at all, provide needed mental health services in the most appropriate treatment setting commensurate with the minor's condition?

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

UNITED STATES CONSTITUTION

Section I, Fourteenth Amendment to the Constitution:

> SECTION 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

GEORGIA STATUTES

Ga. Code §88-503.1:

> 88-503.1. Authority to receive voluntary patients. —(a) The superintendent of any facility may receive for observation and diagnosis any individual 18 years of age, or older, making application therefor, any individual under 18 years of age for whom such application is made by his parent or guardian and any person legally adjudged to be incompetent for whom such application is made by his guardian. If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.
>
> (b) The superintendent of any evaluating facility may receive for observation and diagnosis any individual 14 years of age or older who makes application therefor. If such individual is under 18 years of age, his parent or guardian may apply for his discharge and the superintendent shall release the patient within five days of such application for discharge.

STATEMENT OF THE CASE

In 1969 Georgia adopted a comprehensive and substantially modernized mental health code, codified as Ga. Code Ch. 88-5 (Ga. Laws 1969, p. 505). One major thrust of this Code was to insure that any person who was in need of mental health services and who wished voluntarily to seek State-provided treatment could do so. Recognizing that minors are incapable, because of their lack of maturity, of making such an informed consent as would enable them to receive mental health treatment, the General Assembly of Georgia provided that the parents or guardian of a person under eighteen years of age could act for their child in seeking voluntary treatment for their child's mental illness[1].

Both Appellees were admitted to a State mental health facility in 1970, upon the application of their parents or guardian as provided in Ga. Code § 88-503.1(a). The diagnosis given to J.L. was "hyperkinetic reaction of childhood" (A. 78). J.R. was diagnosed as having "borderline mental retardation" and an "unsocialized, aggressive reaction of childhood" (A. 122)[2].

Since both Appellees were admitted to the State mental health facility pursuant to the provisions of Ga. Code § 88-503.1(a), there were no hearings held where, with the assistance of counsel, they could challenge either the basis of their parents' or guardian's decision to seek psychiatric inpatient therapy for them, or the medical findings and recommendations with respect to the necessity for such treatment.

After their admission to the hospital, both Appellees

[1] *See* Ga. Code § 88-503.1(a).

[2] The summary description of each child's mental illness is taken from the Diagnostic and Statistical Manual of Mental Disorders II (DSM-II), 3rd Edition, published by the American Psychiatric Association.

remained in the State mental health facility, with brief exceptions, until this lawsuit was filed. J.L. was discharged for approximately ten days in 1972, but was readmitted to the hospital upon the application of his adoptive mother and step-father (A. 69). J.R., who had been placed in five foster homes prior to his admission to the hospital, was placed in foster homes on four separate occasions after his original admission to the hospital, but in each case the placement ended with his being returned to the hospital (A. 71-72).

On October 24, 1975, this lawsuit was filed on behalf of the two Appellees, against T.M. "Jim" Parham, the Commissioner of the Georgia Department of Human Resources, W. Douglas Skelton, M.D., the Director of the Mental Health Division of the Department of Human Resources, and W.T. Smith, Chief Medical Officer of Central State Hospital, the Appellants, seeking to enjoin the utilization of that provision of Ga. Code § 88-503.1(a), which recognizes that parents and guardians may make application for admission to a mental health facility for their children under eighteen years of age, and allows State facilities to provide such requested mental health services upon the concurrence of the superintendent of the facility that such services are suitable (A. 1).

The challenge to Ga. Code § 88-503.1(a) was predicated first upon the contention that Appellees were not voluntary patients, but were involuntarily committed to and incarcerated in a State mental health facility without having been afforded a meaningful and complete opportunity to be heard and, consequently, that they had been deprived of their liberty without procedural due process of law.

Second, it was alleged that through the operation of the challenged statute Appellees were placed directly in a mental health facility without any initial or periodic

consideration of placement in a less-restrictive environment[3], and that therefore they had again been denied their liberty without due process of law in violation of the Fourteenth Amendment to the Constitution of the United States.

Shortly after the suit was filed, on November 19, 1975, a three-judge district court was convened and a hearing was held to consider the claims made by the Appellees. After hearing oral argument on the legal issues presented by the complaint, the court directed that the matter be submitted by stipulation and upon testimony taken by deposition.

The Appellants' position at the hearing, and at all other times pertinent hereto, was that the decision to seek hospitalization for a child is one properly made by parents or guardians, who traditionally have been charged with the power and the duty to provide for the maintenance, protection and education of their children. The Appellants argued that children's protection, if any were required, lay in the fact that the parents or guardians could make application for admission to the State mental health facility, but that children could not be admitted unless the superintendent of the facility found that the children showed signs of mental illness and were suitable for treatment in that facility.

The evidence adduced before the district court related primarily to the operation of Ga. Code § 88-503.1(a) and the value of alternatives to that statute suggested by Appellees.

The evidence demonstrated that the Georgia mental health facilities had policies and practices which resulted,

[3] At the time of the filing of this lawsuit the hospital staff was of the opinion that both J.L. and J.R. could be treated for their mental illnesses in a different treatment setting. (A. 109, 156).

prior to the admission of a mentally ill child to the facility, in the consideration of alternative placements for the child (A. 250, 280, 355, 443, 479, 522). The evidence further showed that the facilities conducted a careful screening before admission to insure that the child in fact was mentally ill and suitable for treatment in that particular facility (A. 270, 322, 384, 465, 513 *et seq.*, 548, 588).

With respect to the issue of the periodic review of each child, and the appropriateness of the treatment setting, the evidence indicated that fifty percent of all children admitted under the challenged Code section were released within sixty days of their admission and that eighty percent were discharged within six months (A. 822 *et. seq.*).

There was no substantial evidence introduced which demonstrated that any restrictions were imposed upon any child because of his placement in a State mental health facility, as opposed to any other treatment setting, a significant consideration in light of the subsequent district court order concerning the forty-six children for whom hospitalization was not considered the "most appropriate" treatment setting[4].

Finally, the evidence below demonstrated that the Department of Human Resources, the agency charged with the administration of State-provided mental health services, did not and would not have sufficient funds to provide a full range of "most appropriate" treatment settings for those children presently in its custody, much less for all those who might, in the future, be committed to its custody.

On February 26, 1976, the three-judge district court entered an order holding that the challenged statute and

[4] Opinion of the District Court, Juris. St. 54a.

the practices of the Appellants were unconstitutional. The district court did three things. First, it permanently enjoined and restrained the Appellants from "further detaining or confining" any child under eighteen years of age in any mental health facility of the State of Georgia pursuant to a voluntary admission by a parent or guardian under the challenged provisions of Ga. Code § 88-503.1(a). Second, the court ordered, with respect to those children who were then in State mental health facilities, that the Appellants either (1) commence proceedings within sixty days under some law not found to be unconstitutional to obtain proper legal authority to detain the Appellees or (2) make necessary arrangements to completely remove the Appellees from the custody of the Appellants or any other official or agency of the State of Georgia. Third, the court ordered that, with respect to those children for whom a hospital was not the "most appropriate" treatment setting, Appellants provide the necessary physical resources and personnel for whatever non-hospital facilities were deemed to be most appropriate for those children.

On March 11, 1976, the three-judge district court entered a judgment based on the opinion and order entered February 26, 1976, incorporating its conclusions and directions as set forth above. It is from this order and judgment that this appeal is taken.

SUMMARY OF ARGUMENT

This case presents novel and difficult questions concerning the relationship of parents and their children. The central issue is whether parents may, with the advice of a physician, determine that their children will receive treatment for mental illness in a State mental health facility.

The district court ruled that parents may not make this decision for their children, even with the concurrence of a physician, but rather that the children are entitled to have the issue of their need for hospitalization resolved in an adversarial proceeding. By so holding, the decision of the district court narrows the scope of parents' responsibilities to, and authority over, their children in a fashion which is inconsistent with this Court's prior decisions. *See Wisconsin v. Yoder*, 406 U.S. 205 (1972). Furthermore, the holding of the district court, which is predicated on the finding that psychiatrists and psychiatry are unreliable, fails to give the deference to the medical opinions of physicians required by this Court's decision in *Doe v. Bolton*, 410 U.S. 179 (1973), and is contrary to the evidence in the record which demonstrates that diagnoses by psychiatrists are no less reliable than diagnoses of a number of physical disorders.

It is the Appellants' position that parents may, with the concurrence of a physician, constitutionally make a medically-indicated decision for their minor children, without being hindered by the State. However, Appellants submit that the present case does not provide the proper vehicle for determining that proposition since there is no "state action" involved. The challenged statute, Ga. Code § 88-503.1(a) does not give parents the authority to confine their children; nor does the statute encourage

parents to hospitalize their children. Both the decision to admit the children, and the decision that they are to remain in the mental health facility, belong solely to the parents or guardians as long as the children are mentally ill and suitable for treatment. The State is merely fulfilling a proprietary function similar to that of a private hospital, and it is fundamentally unfair to require that parents be subjected to adversarial hearings and confrontations with their mentally ill children simply because the parents happen to select a State mental health facility for their children, rather than costly private facilities.

Even if the district court is correct in determining that mentally ill children are entitled to some due process prior to hospitalization, the court erred in its determination of "what process is due." This Court in *Mathews v. Eldridge*, 424 U.S. 319 (1976), *Ingraham v. Wright*, ___ U.S. ___, 97 S.Ct. 1401 (1977), and *Smith v. Organization of Foster Families for Equality and Reform*, ___ U.S. ___, 97 S.Ct. 2094 (1977), held that three factors must be considered in any determination of what due process is required in a particular situation: 1) the private interest that will be affected; 2) the risk of an erroneous deprivation of such interest and the probable value, if any, of additional or substitute procedures; and 3) the burden upon the State in providing such additional procedures.

An application of these criteria to the present facts indicates that the procedural rights of children cannot be expanded except at the expense of parents' responsibility and authority, previously recognized by this Court, to decide the direction of their children's upbringing. Moreover, from a practical viewpoint, the evidence indicated that under present procedures children generally are not admitted to State mental health facilities until they have

been seen at a community mental health center, and until alternative placements have been considered. Additionally, children are carefully screened to insure their suitability for hospitalization, not only by the admitting psychiatrist, but also by psychologists, social workers and other mental health professionals.

Not only did the evidence demonstrate that children are sufficiently protected by the present procedures, but most of the persons testifying felt that any additional procedures would merely add unwarranted impediments to the hospitalization of children and that such impediments, in the form of adversarial hearings, would frequently prove harmful to mentally ill children.

In addition to ruling that children are entitled to due process hearings before they can be admitted to State mental health facilities, the district court also determined that the children may be hospitalized only if that is the "most appropriate" treatment setting. In reaching this decision the district court relied upon the "less drastic means" doctrine. However, the application of this constitutional doctrine to the present case is entirely inappropriate, not only because the children are voluntary patients, but also because the "less drastic means" doctrine wrongly presupposes that children possess the same right to liberty as adults, a conclusion which is unsupportable in fact or law.

The district court's decision requires additional procedures where none are needed; it creates situations where children will be denied treatment for their mental illness because the "most appropriate" treatment setting is not available. Neither result is constitutionally mandated, and both portend serious consequences to the very children sought to be protected. The district court's decision should be reversed.

ARGUMENT

I. WHEN A PARENT OR GUARDIAN, ACTING WITH THE CONCURRENCE OF A PHYSICIAN, DETERMINES THAT A MINOR CHILD IS MENTALLY ILL AND IN NEED OF TREATMENT, THE CONSTITUTION DOES NOT MANDATE THAT THERE BE A PROCEDURE THROUGH WHICH THE PARENT'S OR GUARDIAN'S DECISION MAY BE CHALLENGED BY THE CHILD IN AN ADVERSARIAL PROCEEDING.

The special relationship between parents and their children has been recognized throughout recorded history. It is almost universally accepted, both in our society and in others, that parents and guardians have a duty to maintain their children during their infancy, and to make reasonable provision for their children's happiness and well-being[5]. The rationale which supports the relationship, and the relative position of the parents with respect to their children, was well stated by Blackstone in his Commentaries, where he noted:

> "The duty of parents to provide for the *maintenance* of their children, is a principle of natural law; an obligation, . . . laid on them not only by nature herself, but by their own proper act, in bringing them into the world: for they would be in the highest manner injurious to their issue, if they only gave their children life that they might afterwards see them perish. By begetting them, therefore, they have entered into a voluntary obligation to endeavor, as far as in them lies, that the life which they have bestowed shall be supported and preserved. And thus the children will have the perfect *right* of receiving maintenance from the parents." 1 Blackstone, Commentaries, *447. [Emphasis in original].

[5] 1 Children and Youth in America, A Documentary History 363 (R. P. Bremner ed. 1970).

This concept is not merely of historical interest for, as this Court, in *Wisconsin v. Yoder*, 406 U.S. 205 (1972), stated:

> "The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parent in the upbringing of their children is now established beyond debate as an enduring American tradition." 406 U.S. at 232.

This statement by the Court constitutes the capstone to a line of old, established and well-respected[6] cases which recognize, as in *Prince v. Massachusetts*, 321 U.S. 158 (1944), that:

> "It is cardinal with us that the custody, care and nurture of the child reside first with the parents, whose primary function and freedom include preparation for obligations the state can neither hinder nor supply." 321 U.S. at 166.

Through this line of cases this Court has clearly established a "private realm of family life which the state cannot enter" and established that the "sanctity of the family"[7] is constitutionally protected against State interference.

Hence, the State, both as a matter of tradition and as a result of this Court's decisions, is precluded in most instances from interjecting itself into the parents' decision-making process and from requiring parents to submit their decisions, once made, to scrutiny in an adversarial proceeding.

[6] *See Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

[7] *Moore v. East Cleveland*, ____ U.S. ____, 97 S.Ct. 1932 (1977).

A parent's constitutional right to family privacy and autonomy, particularly with respect to his child, is not without limits. However, the parameters established by this Court and others, which limit the parents' responsibilities and authority, are clearly predicated upon considerations having nothing to do with the parents' ability and responsibility to make medically-indicated decisions, with the concurrence of a physician, for their minor children[8]. Rather, these parameters are almost uniformly predicated on the concept that parents may not make certain types of decisions which, while requiring the services of a physician, are based on particular social or moral beliefs of the parents which may not reasonably be expected to be shared by the child.

Thus, this Court has held that parents may not prevent their unmarried minor child from obtaining an abortion, if the child so desires. *See Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976). Similarly, state courts have held that parents cannot have their children sterilized, irrespective of the parents' motivations where the health of the child is not involved. *See, e.g., L. v. H.*, 325 N.E. 2d 501 (Ind. 1975), *cert. denied*, 425 U.S. 936 (1976).

[8] In addition to the establishment by some courts of parameters beyond which parents may not make decisions for their minor children, other courts have established certain duties which parents must discharge. Notably, a great number of courts have held that parents and guardians have an obligation to provide proper medical treatment for their child and may be forced to provide such treatment if they do not do so voluntarily. *See Wallace v. Labrenz*, 411 Ill. 618, 104 N.E. 2d 769, *cert. denied*, 344 U.S. 824 (1952). Furthermore, these same courts have also held that the failure to provide the requisite medical attention for a child may constitute criminal neglect on the part of the parent or guardian. *See Singleton v. State*, 33 Ala. App. 536, 35 S. 2d 375 (1948); *State v. Beach*, 329 S.W. 2d 712 (Mo. 1959). Of course, in addition to these court decisions, most states have child abuse statutes which place restrictions on the authority of parents and guardians over their children. *See, e.g.*, Ga. Code § 26-2801.

Even though there are limits beyond which a parent may not go, a parent making a medically-indicated decision for his child, particularly when the decision is concurred in by a physician, has always, but for a few recent lower court decisions, been considered to be acting well within these parameters. *See Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975) *rev'd and remanded*, — U.S. —, 97 S.Ct. 1709 (1977); *Saville v. Treadway*, 404 F. Supp. 430 (M.D. Tenn. 1974). Unfortunately, the decision of the district court would change this general rule by holding that certain medically-indicated decisions of a parent, particularly those concurred with by a psychiatrist, must be subjected to scrutiny in an adversarial hearing before those decisions may be implemented.

As justification for this dilution of the authority of a parent to seek and obtain medical assistance for his child, the district court stated that:

> "[P]sychiatry according to psychiatrists is still an inexact science as to which there is the opportunity for wide, sincere differences of opinion among psychiatrists."[9]

The district court concluded, saying:

> "Since they are capable of erring, psychiatrists like parents cannot statutorily be given the power to confine a child in a mental hospital without procedural safeguards being interposed to guard against errors in judgment. . . ."[10]

With this language, the district court has tried to establish a yardstick by which to measure the extent of a parent's authority over his child. A parent's decision concerning the advisability of a particular type of medically-

[9] Opinion of the District Court, Juris. St. 51a.

[10] Opinion of the District Court, Juris. St. 52a.

indicated treatment is to be subjected to scrutiny in an adversarial proceeding, even if the decision is concurred with by a physician, whenever there is an "opportunity for wide, sincere differences of opinion" within the medical profession about the necessity of the treatment[11].

This new criterion, however, is based on substantially the same premise advanced by the State and rejected by this Court in *Doe v. Bolton*, 410 U.S. 179 (1973). There the Court, in overturning the State's requirement that a physician seek and obtain the concurrence of a number of his peers before performing an abortion, noted that:

> "If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. . . . Required acquiescence by copractitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice." *Id.* at 199.

Moreover, as this Court held in *Doe v. Bolton, supra*, the attending physician will recognize when a consultation is advisable, will recognize the "need for assurance when the medical decision is a delicate one."

Therefore, this Court and others have recognized that physicians can and should be trusted to provide competent medical assistance, and that requiring a review of

[11] Opinion of the District Court, Juris. St. 51a. The application of the district court's test could have some interesting but bizarre results. The Appellees' witness, Dr. Eli Messinger, indicated that the medical value of a tonsillectomy is questionable, concluding that ". . . I was myself a victim of a tonsillectomy. . . ." Testimony of Dr. Eli Messinger (A. 193). Using the district court's criterion of requiring the application of due process safeguards where there are sincere and wide differences of medical opinion concerning the necessity for a particular type of treatment, coupled with a risk to the patient's life or liberty, the medical decision as to whether to perform a tonsillectomy would require scrutiny in an adversarial proceeding, if performed in a public hospital.

the physician's exercise of the discretion vested in him is inappropriate. As the Supreme Court of New Jersey noted in the celebrated case of Karen Ann Quinlan[12], citing the lower court's decision:

> "Doctors . . . to treat a patient, must deal with medical tradition and past case histories. They must be guided by what they do know. The extent of their training, their experience, consultation with other physicians, must guide their decision-making processes in providing care to their patient. The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts?" 355 A.2d at 665.

Thus, the district court's conclusion that the decisions of physicians may be, and, in specific cases, must be scrutinized by courts or other independent observers, is thoroughly inconsistent with this Court's conception of the deference properly to be given to medical opinion, and also constitutes the "gratuitous encroachment upon the medical profession's field of competence,"[13] which other courts routinely avoid. For this reason alone the district court's decision should be reversed.

Additionally, the opinion of the district court should also be reversed for another reason. The district court's decision is predicated on the idea that psychiatrists and psychiatry are unreliable, because psychiatrists supposedly disagree routinely on the particular labels and diagnoses to be given to mentally ill persons.

[12] *In the Matter of Quinlan*, 70 N.J. 10, 355 A. 2d 647 (1976).
[13] *Id.* at 669.

It is true that not every diagnosis of a psychiatrist will be concurred in by all of his contemporaries, but there is little evidence in the record that psychiatry is an "inexact science," as the district court used that phrase.

By way of illustration, the evidence before the district court clearly indicated that the reliability of the diagnosis of a number of physical disorders is no better than the reliability of the diagnosis of mental illness[14]. While the diagnosis of mental illness may be complex, and while psychiatry may have been late in developing as a separate branch of medicine, it is difficult even for a layman to accept the validity of the proposition advanced by one of the Appellees' witnesses that in the past fifteen years no improvement has been achieved in the reliability of psychiatric diagnosis[15]. A better conclusion is that the substantial evidence in the record does not support the

[14] "The issue that interests me was the reliability in schizophrenia versus the reliability in physical disorders, and when you look at the reliability in physical disorders, you find that the frequency of reliability is no better in a variety of physical disorders, from tonsillectomies to cardiac diseases to the pap smear, or the diagnosis for cancer of the cervix, as compared with diagnosis for the particular mental illness called schizophrenia." Testimony of Dr. Arthur Falek (A. 690). *See Falek and Moser, Classification in Schizophrenia*, 32 Arch. Gen. Psychiatry 59 (1975).

"The first study is an early investigation by Bakwin of the need for tonsillectomies in 389 children evaluated by three physician-observer groups. All of the children were examined by a first-observer group; those not considered in need of tonsillectomies were then evaluated by the second-observer group, and so on. Of interest is the fact that the 55.3% considered normal by the first-observer group was reduced to 16.7% by the time the third-observer group of physicians completed their examinations." [footnote omitted] *Id.* at 63.

"The difficulty in diagnosing angina is confirmed in a study of 57 chest pain patients; data on the consistency of diagnoses by three cardiologists for each of these patients evaluated after 15-minute interviews shows only a 45% concurrence among the three specialists." [footnote omitted] *Id.*

[15] Testimony of Dr. Eli Messinger (A. 192).

district court's conclusion as to the profession's lack of reliability but rather that the contrary is true[16].

Moreover, a great deal of the literature in the field of psychiatry disputes the Appellees' contention, and the district court's findings, as to the reliability of a psychiatric diagnosis. One measure of the reliability of a diagnosis of a condition is the consistency between independent diagnoses of that condition. Studies have demonstrated that independent physicians can reliably diagnose depression with correlations of .8 or .9 (80 to 90 percent agreement)[17]. Other studies have shown that reliability measures are also significant on self-rating scales[18] and highly reliable physiological measures and the physician's judgment of the severity of depression are correlated[19], all of which demonstrates a degree of reliability[20] in psychiatric diagnosis not recognized by the district court.

Indeed, the decision of the district court is internally inconsistent in this respect. On the one hand the district court decided that psychiatry was such an inexact science that the decisions of psychiatrists that hospitalization would be appropriate for a child had to be reviewed by

[16] "It's like diagnosis in any field of medicine. It's not one hundred percent perfect, but the studies range from—if you're looking at observer agreement then it would be fifty-five percent, if you look at . . . diagnostic concordance, then you'd see figures as high as eighty-five, ninety-five, ninety-seven percent in some of the studies, so it's not something you can make a global statement about, that all psychiatric diagnoses are unreliable." Testimony of Dr. W. Douglas Skelton (A. 234).

[17] Bunney and Hamburg, *Methods of Reliable Longitudinal Observation of Behavior*, 9 Arch. Gen. Psychiatry 114 (1963).

[18] Zung, *Self-Rating Depression Scale in an Outpatient Clinic*, 13 Arch. Gen. Psychiatry 508 (1965).

[19] Kupfer, *Interval Between Onset of Sleep and Rapid-Eye-Movement Sleep as an Indication of Depression*, Lancet 684 (Sept. 30, 1972).

[20] *See also*, Sandifer, *Psychiatric Diagnosis: A Comparative Study in North Carolina, London and Glasgow*, 114 Br. J. Psychiatry 1 (1968).

independent observers. Then the district court, in considering the disposition of the children, admitted:

> "It is not for this court of three lay judges to choose the appropriate, less drastic form of care for each of these children; that decision we leave to the professional judgment of the defendant psychiatrists."[21]

It is difficult to understand why the defendant psychiatrists cannot be relied upon to make a valid determination as to whether a child is suitable for treatment in a hospital, yet are evidently perfectly competent to determine that a child may be placed, perhaps against his will, in other settings which from all that the record discloses may involve the same or more stringent restrictions than hospitalization.

Moreover, the decision of the district court is even more difficult to understand in view of the fact that the court was unable to conclude that even a single child had been either not mentally ill or not suitable for treatment when initially hospitalized. The court in its opinion did not identify any child who could have benefited from the preadmission hearings mandated by the court.

This Court's decision in *Doe v. Bolton*, *supra*, recognizes the existence of a presumption that physicians are competent to make the medical decisions required of them, and the evidence supports the application of this presumption to the present case. To conclude with the finality of the district court's order that the decisions of psychiatrists are deserving of review constitutes an indictment of the psychiatric profession which is unwarranted, in conflict with the concepts established by this Court, and unsupported by the evidence in the record. To the extent that the decision of the district court is predicated

[21] Opinion of the District Court, Juris. St. 54a.

upon this unwarranted and unsupportable conclusion, it is clearly erroneous; it constitutes an unjustified intrusion into the constitutionally protected responsibilities of parents to guide the direction and upbringing of their children, as well as upon the right of a physician to practice his profession. It is a conclusion which the district court could not permissibly reach and which should be reversed.

II. WHEN A PARENT VOLUNTARILY SEEKS AND RECEIVES MENTAL HEALTH SERVICES FOR HIS MINOR CHILD FROM A STATE AGENCY, THERE IS INSUFFICIENT "STATE ACTION" TO IMPLICATE THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT TO THE CONSTITUTION OF THE UNITED STATES.

Argument I, *supra*, was concerned with the issue of whether, when a parent makes a medically-indicated decision for his minor child, the State, through its judiciary or otherwise, has any authority or duty to require that the parent submit his decision to an adversarial challenge.

A closely related issue is whether, when the parent receives medical assistance or services from a State mental health facility, the parent's decision-making process is thereby imbued with that quantum of "state action" necessary to implicate the Due Process Clause of the Fourteenth Amendment to the Constitution.

The issue of what state involvement transforms private action into "state action" has been widely debated. One conclusion which is almost universally accepted is that not every service or benefit provided to a private party by a state will cause the private action to be subjected to

the limitations imposed by the Fourteenth Amendment[22].

More particularly, there is a constant thread throughout the case law on "state action," that in each instance the state must be found to have either: (1) affirmatively delegated its power to the entity engaging in the activity sought to be prohibited[23]; (2) so intertwined its activities with the private activities complained of that the state's interests and the private interests are inseparable[24]; or (3) encouraged, enforced, or affirmatively aided or supported the activity sought to be prohibited[25].

While no objective test, applicable to every situation, for determining the presence of "state action" has been formulated, it is clear that state involvement in a private activity does not constitute "state action" unless it appears that the state involvement creates, aids, encourages or enforces the activity.

In this case neither the admission of a child to a State mental health facility nor the services provided the child and parent after the child's admission constitutes "state action."

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[22] In *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 173 (1972), it was noted that: "The Court has never held . . . that discrimination by an otherwise private entity would be violative of the Equal Protection Clause if the private entity receives any sort of benefit or service at all from the State. . . . Since state-furnished services include such necessities of life as electricity, water and police and fire protection, such a holding would utterly emasculate the distinction between private as distinguished from state conduct. . . ."

[23] *Adickes v. S.H. Kress Co.*, 398 U.S. 144 (1970).

[24] *Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961).

[25] *Reitman v. Mulkey*, 387 U.S. 369 (1967); *Shelley v. Kramer*, 334 U.S. 1 (1948).

A. The decision of the parent to seek treatment for his mentally ill child in a State mental health facility does not constitute "state action" for the purposes of the Due Process Clause of the Fourteenth Amendment to the Constitution.

The statute challenged here does not purport to grant to the parents of a mentally ill child the right to cause that child to receive whatever treatment the parent determines is medically indicated. The challenged statute merely authorizes the superintendent of a facility to admit a child on the application of his parents if in fact the child is mentally ill and suitable for treatment.

The authority of the parents comes, instead, from the traditional relationship between a parent and his child, the origins of which were discussed in Argument I, *supra*. This relationship is clearly supported by the decisions of this Court, which have recognized the parents' responsibility to raise and care for their children in the manner they deem most appropriate[26].

Thus, the ultimate decision as to whether to hospitalize a child rests with his parents. The function of the State under the challenged statute is to provide a resource if it is needed, and to provide a system to insure that the State does not become party to unnecessary hospitalizations. The superintendent does not decide that the child will be hospitalized; he merely decides whether the hospital will be made available for a particular placement.

This distinction is significant because parents can refuse to seek admission for a child even when the superintendent would find hospitalization appropriate, and parents can remove a child from the hospital even if the

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[26] *See, e.g., Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

superintendent believes that continued hospitalization would be appropriate[27].

Thus, unlike the situation in *Reitman v. Mulkey*, 387 U.S. 369 (1967), and cases of that genre, the State is not actively encouraging the hospitalization of children, nor does the State, through the challenged statute, convey to the parents the power to effectuate the hospitalization. Rather, the State's position is more akin to the government's position in *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974), where this Court noted:

> "Approval . . . of such a request (for authority to terminate services to a customer by a public utility) . . . where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmit a practice initiated by the utility and approved by the commission into 'state action'. . . . Respondent's exercise of the choice allowed by law where the initiative comes from it and not from the State, does not make its action in doing so 'state action' for the purpose of the Fourteenth Amendment." *Id.* at 357 [Parenthetical matter added].

Here, as in *Jackson v. Metropolitan Edison Co.*, the challenged law merely offers a private party a choice. The State does not order children hospitalized nor does it seek out prospective patients. It simply makes available an alternative, which parents or guardians are free to select, if appropriate, or reject. It is the parents' or guardians' initiative and their decision, that result in the hospitalization of the child, rather than the actions of the State.

Moreover, for this Court to determine that the provision of this resource constitutes "state action" would

[27] Testimony of Dr. James Craig (A. 530).

result in fundamental unfairness. Parents are completely free to take their children to a private mental health facility, if they wish. If they do, and the child is admitted, the child is offered none of the procedures sought in this lawsuit. The child can be placed in the private institution and kept there indefinitely without ever having an opportunity to challenge his hospitalization in the manner ordered by the district court. Society and the State rely, as this Court in *Doe v. Bolton*, *supra*, determined that they should, on the medical judgment of the physicians at such facilities to see that proper services are provided.

Yet under the district court's decision, whenever a parent exercises the choice given by the challenged law, he will find himself faced with an adversarial hearing, the expense of a lawyer and, in essence, an undesired and undeserved confrontation with his ill child. The fact that the parent has selected, for whatever reason, a State mental health facility rather than a private facility, provides neither a sufficient nor a reasonable basis for concluding that "state action" is present.

B. The activities of the State, after a child is admitted to a State mental health facility, do not constitute "state action" for the purposes of the Due Process Clause of the Fourteenth Amendment to the Constitution.

This lawsuit does not challenge the quality of care rendered to hospitalized children, but rather complains of a perceived lack of due process in the procedures resulting in hospitalization and the continuance of hospitalization once begun. Just as there is no "state action," using the criteria set forth previously, in the decision to hospitalize the child, neither is there sufficient "state action" in continuing the hospitalization to implicate the Due

Process Clause of the Fourteenth Amendment.

Once a child is admitted to the hospital, by the terms of the challenged statute, the child is classified as a voluntary patient and, with one exception, the child has all the rights of any voluntary patient.

Among the rights which each voluntary patient has is the right to request his discharge at any time after five days following his admission to the facility[28]. That is, when a voluntary patient requests his discharge, the superintendent must discharge the patient unless he finds the discharge would be unsafe to the patient or others, in which case the State's involuntary hospitalization procedures, which have not been challenged in this suit, must be followed.

The exception noted is that the statute provides if the voluntary patient was admitted upon the application of his parent or guardian, the patient's discharge prior to his becoming eighteen years of age may be conditioned upon the consent thereto of his parent or guardian.

The reason for this exception is well-founded. The criteria for admission of a voluntary patient are merely that the patient be mentally ill and suitable for treatment. An adult, however wrong the decision may be, is free to choose to leave the hospital even though he is still mentally ill and his illness may be suitable for treatment at the hospital, for he is assumed to be capable and compe-

[28] Ga. Code § 88-503.3. "A voluntary patient who is admitted to a facility pursuant to section 88-503.1, or his legal guardian, parent, spouse, attorney or adult next-of-kin, may request his discharge in writing at any time after five days following his admission to the facility. . . . If the patient was admitted before the age of 18 on the application of his parent or guardian under section 88-503.1, his discharge prior to becoming 18 years of age may be conditioned upon the consent thereto of his parent or guardian."

tent to assume the risk attendant upon being discharged from the hospital against the medical advice of his attending physician.

However, children cannot be treated as adults, with respect to receiving medical treatment. Children oftentimes do not appreciate that medical treatment is for their own good and thus may attempt to avoid receiving medical treatment for reasons which are neither rational nor logical[29]. For this reason, the statute recognizes the responsibility of the parent, or guardian, to determine whether his mentally ill child, who is still suitable for treatment in the mental health facility, may assume the risk of leaving the hospital against medical advice. The decision that the mentally ill child must remain is made solely by the parent or guardian, and the mental health facility may not make that decision for the parent, as long as the child does not meet the criteria of the State's involuntary commitment statute[30]. The State's involvement is reduced to the responsibility of every medical facility, whether private or public: the rendering of medically-indicated treatment upon the request of the person, or one legally responsible for the person.

Interestingly enough, as noted before, not only does the parent have the right to make the independent deci-

[29] Testimony of Dr. John Filley (A. 744). Dr. Eli Messinger concurred stating: "I would say to the parents that they should use their authority to bring the child in and I would explain to the child that whether he liked it or not, we as adults saw this as a grave situation and that perhaps he didn't understand it now, but we assumed that he would eventually understand our action." Testimony of Dr. Eli Messinger (A. 208).

[30] The Georgia Code provides that a person may be involuntarily committed to a State mental health facility if the person is (1) mentally ill and (2) either likely to injure himself or others if not hospitalized or is incapable of caring for his physical health and safety. Ga. Code § 88-506.1.

sion that the child is to remain in the hospital, even though the child does not desire to do so, but the parent also has the authority to withdraw the child from the hospital at any time, irrespective of the fact that the child is still mentally ill, is still suitable for treatment and may prefer to remain in the hospital. The State is helpless to prevent this from occurring unless the State either seeks to involuntarily hospitalize the child, utilizing the involuntary hospitalization procedures of the Georgia Mental Health Code, or files a petition in the juvenile court alleging that the parents are depriving the child of proper medical treatment through their action.

Thus, the decision to maintain a child in a State mental health facility, if the child is mentally ill and suitable for treatment, or to remove the child from the facility, is a decision which can only be made by the parent or guardian. The hospital acts as a provider of medical services, not as a prison. The State is simply another provider of services obtainable from any number of private facilities; to assert that this rises to the level of "state action" is to make a mockery of the concept that not every instance of state involvement in private activities implicates the Due Process Clause of the Fourteenth Amendment.

III. THE CHALLENGED STATUTE AND THE ADMINISTRATION OF THAT STATUTE SATISFY THE CONDITIONS IMPOSED BY THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT TO THE CONSTITUTION OF THE UNITED STATES.

Even if the district court was correct in determining that a parent's decision to hospitalize a mentally ill child in a State mental health facility mandates a system of checks and balances to insure that parents do not abuse

their authority, the district court's conclusion as to the scope of "what process is due" was erroneous.

It is axiomatic that not every infringement upon a constitutional right requires the same form of due process[21]. Instead this Court has held, as in *Mathews v. Eldridge*, 424 U.S. 319 (1976), that the identification of the specific dictates of due process in any particular situation generally requires consideration of three distinct factors: (1) the private interest that will be affected by the official action; (2) the risk of an erroneous deprivation of such interest by the procedures presently used, and the probable value, if any, of additional or substitute procedural safeguards; and (3) the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

The applicability of these criteria to the present case and the result thereof are clearly affected by this Court's recent decisions in *Ingraham v. Wright*, — U.S. —, 97 S.Ct. 1401, 51 L.E.2d 711 (1977), involving the question of children's rights to procedural due process safeguards prior to the imposition of corporal punishment, and *Smith v. Organization of Foster Families for Equality and Reform* (hereinafter cited as OFFER), — U.S. —, 97 S.Ct. 2094 (1977), having to do with the sufficiency of protections afforded by New York to foster parents upon the removal of their foster children.

Each of these considerations will be examined separately.

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[21] *See, generally, Goss v. Lopez*, 419 U.S. 565 (1975); *Morrissey v. Brewer*, 408 U.S. 471 (1972); *Cafeteria Workers v. McElroy*, 367 U.S. 886 (1961); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306 (1950).

A. The challenged statute successfully balances the right of a parent to exercise control over the care and upbringing of his child, with the child's limited right to liberty.

Any consideration of the first factor noted in *Mathews v. Eldridge*, *supra*, *Ingraham v. Wright*, *supra* and *OFFER*, *supra*, must immediately focus on the number of competing private interests which are involved in this suit. Here the principals, irrespective of how the case is styled, are parents and their children, and the particular interests affected by the case are the rights of the parents to seek medically-indicated treatment for their child, as opposed to the child's right to contest his hospitalization in a State mental health facility. These interests are competing and the procedural rights of the child can only be expanded at the expense of the rights of the parents. That is, if the child is afforded the due process procedures which the district court has mandated, the right of the parent to determine what medically-indicated treatment is to be provided to his child, must necessarily be narrowed.

In determining where the proper balance lies, it is significant to note that the constitutional interests involved are not of the same magnitude. Historically, this Court has recognized that the parent has a right to determine the type of care to be given to the child, within certain parameters, and that the State has no authority to interfere in these decisions. *See Wisconsin v. Yoder*, *supra*; *Prince v. Massachusetts*, *supra*.

On the other hand, a minor's liberty interest, *vis-a-vis* the State, is limited. For instance, the State can limit a minor's access to certain types of books[32], can affect a

[32] *Ginsberg v. New York*, 390 U.S. 629 (1968).

minor's right to vote[33], can limit a child's access to alcoholic beverages[34], and can even limit a child's ability to earn a livelihood[35]. Further, even though this Court in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), has held that parents may not exercise an absolute veto over their minor child's right to an abortion, this Court did recognize in *Bellotti v. Baird*, 428 U.S. 132 (1976), that a statute which gives a parent some control over the minor's decision to have an abortion, and which forces the minor child to seek court approval of the abortion, may be constitutionally appropriate, even though similar strictures could not be placed upon an adult.

In determining the nature of the child's liberty interest in the present case, reliance on such cases as *In re Gault*, 387 U.S. 1 (1967) and *McKeiver v. Pennsylvania*, 403 U.S. 528 (1970), is misplaced. In each of those cases and its progeny, the children involved had run afoul of the laws of the State, laws in which the State had an enforcement interest. The rights of the juvenile were in conflict with the State interest in enforcing its own laws. "Such due process cases are inapplicable to a case such as this where the state interest . . . coincides perfectly with [the child's] interest." *Drummond v. Fulton Co. Dept. of Family and Children Services*, 547 F.2d 835, 860 (5th Cir. 1977) (Roney, J., dissenting) (rehearing *en banc* granted).

Thus, what is actually at issue is whether the present procedures used to provide for the hospitalization of a mentally ill child are so fraught with the possibility of error on the part of the parent and the physician that the

[33] *Oregon v. Mitchell*, 400 U.S. 112 (1970).

[34] *Republician College Council of Pennsylvania v. Winner*, 357 F. Supp. 739 (E.D. Pa. 1973).

[35] *Prince v. Massachusetts*, 321 U.S. 158 (1944).

parent's very broad responsibility to see to the care and welfare of his child must be limited and the limited rights of the child expanded through the imposition of more rigorous procedural impediments to hospitalization.

B. The risk of an erroneous deprivation of the child's liberty interest, with the procedures presently used, is inconsequential and the probable value of additional or substitute procedures is insignificant.

The second factor noted in *Mathews v. Eldridge, supra, Ingraham v. Wright, supra,* and *OFFER, supra,* involves an evaluation of (1) the risk of an erroneous deprivation of a child's liberty interest by the procedures presently used to hospitalize a child; and (2) a consideration of the probable value of additional or substitute procedural safeguards. The evidence presented to the district court clearly indicates that the procedures presently[36] used are

[36] The remarks of the dissent by Judge Roney in *Drummond v. Fulton Co. Dept. of Family & Children Services,* 547 F. 2d 835, 860 (5th Cir. 1977) [rehearing *en banc* granted], made in reference to Georgia's foster care system, seem so pertinent to the mental health delivery system as to warrant extensive quotation:

> "The [physicians and parents] who made the decision about [the Appellees] were more intimately acquainted with them, their past history and any potential problems, than any hearing officer [or judge] could ever be. I think that this form of rational decision making is all that is required. Due process does not mean the kind of adversarial hearing with which courts are so familiar. The factors that must be weighed in deciding if a [mentally ill] child could have a successful [treatment] in a particular [setting] are so complex and ephemeral that adversarial procedures are inappropriate. The [professional] system of [mental health services] established by the state for the processing of these very difficult personal and social decisions should not be destroyed under a constitutional edict. Limitations of time, money and human resources may well dictate the methodology of the state agency, but as long as all legal interests of the parties are reasonably protected, the state procedure is not subject to constitutional supervision." [Bracketed matter added].

sufficiently thorough so as to essentially preclude the risk of an erroneous deprivation of the child's liberty and the district court's conclusion to the contrary was erroneous.

Initially, the evidence presented to the district court demonstrated that, with the exception of emergency admissions, children are normally referred to community mental health centers prior to any consideration of their admission to a hospital[37]. In most instances, only after community resources have either been eliminated or exhausted, are the children brought to the regional hospitals[38].

Once it is determined that the child cannot be treated in the community and that hospitalization may be indicated, the child is subjected to a thorough screening procedure at each regional hospital[39]. While a physician makes the ultimate determination that a child is to be admitted to a hospital, the evaluation of the data available involves a "team" approach involving not only the

[37] "[T]he child is admitted through a community program. To explain that further, it is our feeling that children should not simply be admitted directly to the hospital. . . . So any referral for admission is first of all processed, or evaluated, by community mental health people, and then, if institutional admission is to be considered, the institutional staff is involved in a final determination of what the treatment plan will be for that child, and that child's family." Testimony of Dr. Eugene Jarrett, III, (A. 443); *See also* testimony of Drs. Bowling, (A. 355); Mazur, (A. 479); Craig, (A. 522); and Gates, (A. 280).

[38] "[T]he basic philosophy of the hospital, is that persons will be treated in the comprehensive community mental health centers in every possible instance, rather than being hospitalized." Testimony of Dr. Lawson Bowling, (A. 355); *See also* testimony of Drs. Jarrett, (A. 446); and Mazur, (A. 481).

[39] *See, e.g.,* Dfs. Ex. 4 to testimony of Dr. John Gates, (A. 322, 283); Dfs. Ex. 2 to testimony of Dr. James Craig, (A. 548, 522); and Dfs. Ex. 2 to testimony of Dr. Lawson Bowling, (A. 384, 353).

psychiatrist, but social workers, psychologists and other mental health professionals[40].

Moreover, the evidence presented to the district court indicated that the persons making the decision were not required to make that decision based solely upon their observations of the child and information supplied by his parents. The testimony of the superintendents clearly indicated that, as a part of the screening procedures, information was actively sought from the community mental health centers involved and that contact was made in various instances with the child's school, the child's parents, other relatives, county departments of family and children services, local law enforcement agencies and even courts, when appropriate[41]. Thus, the decision by the hospital that a child is suitable for treatment is not an "unchecked and unbalanced" decision made by a single psychiatrist acting in a vacuum, but rather is the result of a procedure involving input from a number of different persons and from a number of different sources.

Perhaps the most interesting point of the district court's opinion, with respect to this issue, is not what the opinion said, but what it did not say. The district court's opinion is very lengthy and detailed, yet the district court did not identify a single child who was at the time of his initial hospitalization neither mentally ill nor unsuitable for treatment in the hospital. The district court did not find that J.L., J.R. or any member of the class they represent had been initially hospitalized inappropriately. The Court found instead that forty-six of the children in the hospital "could now be treated and cared for in non-hospital surroundings if such were only available."

[40] "[T]he kinds of persons that are involved . . . are called screening coordinators, who are appointed by the program director of the . . . children's service, and . . . [include] . . . social workers, psychologists, an assistant director of education and a psychiatrist." Testimony of Dr. Bowling, (A. 358). *See also*, testimony of Drs. Gates, (A. 280); Kuglar, (A. 558); and Mazur, (A. 508).

[41] "[The staff] also try to contact any other people [parents, relatives, schools, D.F.C.S., juvenile courts] who may have been involved with this child prior to admission to see what information they can gather that would bear on the disposition of the child." Testimony of Dr. John Gates, (A. 284).

In evaluating the risks of an erroneous deprivation of a child's liberty under the present procedures it is significant that the district court's opinion is absolutely silent as to any specific instance where the admission system had proved faulty. Certainly the district court found that on occasion when a child is ready to leave the hospital, there is no place ready to receive him, but the district court's opinion does not in any way demonstrate, or find as a fact, that the difficulties that a child has in finding a place to go could have been prevented by a preadmission hearing.

Even though some children may remain in the hospital when other settings may be more appropriate, this does not result from a failure in the admission procedures or through the failure of the hospital to identify their needs. Each superintendent indicated that there existed in each of the institutions a policy requiring periodic reviews of the status of each patient to determine whether the child continued to be mentally ill and suitable for treatment at the hospital[42]. The viability of this review system is clearly supported by the fact that fifty percent of all the children admitted to State hospitals are released within

[42] "[T]he 'staffing procedure' . . . involves an initial assessment of the problem, the formulation of the treatment plan, and . . . that is followed up by the regular rounds at which that is reviewed. . . . There's a review of each case once a week." Testimony of Dr. Lawson Bowling (A. 359).

sixty days after admission, and eighty percent are released within six months[43].

However, if a child has been inappropriately hospitalized, or remains hospitalized when hospitalization is no longer appropriate, the Georgia Code contains a number of provisions which may be immediately utilized to remedy the situation.

Specifically, Ga. Code § 88-502.11(b) provides that a patient or his representative may file a petition in the probate court of the county in which the patient is hospitalized, alleging that a procedure authorized by Ga. Code Ch. 88-5 is being abused[44]. Thus, if a child is hospitalized who is not mentally ill or if a child is hospitalized who is not suitable for treatment, or if the superintendent of a facility retains a child after a reasonable person would conclude that hospitalization is no longer desirable, the probate court of the county in which the hospital is located has an absolute and unfettered right to correct the situation by ordering the child released from the facility or by ordering whatever other relief may be appropriate.

In addition to the provisions of Ga. Code § 88-502.11(b), Ga. Code § 88-502.11(a) provides that at any time and

[43] The evidence presented to the district court clearly established that the hospital personnel had established contact and actively sought the removal of the Appellees from the State hospital, when the hospital personnel determined that there existed another treatment setting which might be more appropriate for the Appellees. Testimony of Ann Etheridge, (A. 658-59).

[44] Ga. Code § 88-502.11(b) provides as follows: "A patient or his representatives may file a petition in the probate court in the county in which the patient is hospitalized, alleging that the patient is being unjustly denied a right or privilege granted by this Chapter or that a procedure authorized by this Chapter is being abused. Upon the filing of such a petition, the court shall have the authority to conduct a judicial inquiry and to issue any appropriate order to correct any abuse of the provisions of this Chapter."

without notice a person detained in a facility, or a relative or friend of such person, may petition for a writ of habeas corpus to question the cause and legality of the detention of the person[45]. Hence, again, if a child is either not mentally ill or is improperly hospitalized, the Code makes specific provision for an application for a writ of habeas corpus to challenge the legality of the confinement.

Finally, Ga. Code Title 24A, the Juvenile Court Code of Georgia, makes specific provision for children who have been (1) placed for care in violation of law or (2) who have been abandoned by their parents or other legal guardians by declaring such children to be "deprived."[46] Georgia Code § 24A-1602 provides that any person has standing to file a petition, alleging the deprivation of a child. If the juvenile court, after hearing, finds that the child is not being cared for properly or is otherwise deprived, the juvenile court has complete and unlimited jurisdiction to make suitable provisions for the child. Appellees have not suggested, nor could they show, that these statutory remedies are ineffective.

In addition to providing these remedies, the Georgia Code provides that the State's Department of Human Resources must see that each patient is given the opportunity to secure legal counsel to represent him in these

[45] Ga. Code § 88-502.11(a) provides as follows: "At any time and without notice, a person detained by a facility or a relative or friend on behalf of such person may petition, as provided by law, for a writ of habeas corpus to question the cause and legality of detention and to request the court on its own initiative to issue a writ for release."

[46] Georgia Code § 24A-401 provides *inter alia*, that a deprived child is a child who "(2) has been placed for care or adoption in violation of law; or (3) has been abandoned by his parents or other legal custodian."

matters[47]. Counsel for Appellees were provided office space by the very persons they are now suing. Moreover, it was the staff of the hospital itself that referred Appellees to their counsel.

The system created by the Georgia Code for the voluntary hospitalization of mentally ill children works, and works well. For those very few instances where the system might fail, there are sufficient legal remedies, meaningful legal remedies, so as to preclude a wholesale rejection of the voluntary hospitalization process, as is advocated by the Appellees.

In addition to the issue of the efficacy of the present procedures surrounding the hospitalization of children, the second factor set forth in *Mathews v. Eldridge*, *supra*, *Ingraham v. Wright*, *supra*, and *OFFER*, *supra*, requires an examination of whether any additional procedures or safeguards would provide a better method of insuring that the liberty interest of the children, however limited, is better protected. Although the evidence is in conflict, the overwhelming bulk of the evidence presented to the district court indicates that additional or more formalized procedures are unnecessary, and in fact that such procedures may be harmful and detrimental to the children.

Appellees in their complaint, in essence, asked for a hearing replete with all the trappings normally associated with an adversarial proceeding, including the right to counsel, the right to subpoena witnesses, the right to cross-examine the person seeking the hospitalization for

[47] Ga. Code § 88-502.12 provides as follows: "It shall be the responsibility of the department to see that every patient is given the opportunity to secure legal counsel to represent him in connection with private, personal, domestic, business, civil, criminal, and all other legal matters in which he may be involved during hospitalization."

the child, and a host of other rights more compatible with a criminal proceeding than with the hospitalization of a mentally ill child.

As justification for more formalized proceedings, Appellees' position is that such a proceeding would result in the production of more information, which would provide a better foundation for making the decision whether to hospitalize the child either by opening up new sources of information or by providing a forum in which a more complete and accurate examination of the child's needs could be made.

However, the Appellants' evidence demonstrated that all of the sources of information which Appellees' witnesses felt were important were already known to the superintendents, and were utilized[48]. Furthermore, the evidence clearly indicated that mental health personnel are trained specifically to elicit information concerning the condition of prospective patients, and that it is doubtful that a lawyer on cross-examination could get any more beneficial information than could a psychiatrist through the application of skills particularly cultivated for that purpose over a period of years[49].

[48] *See, e.g.*, testimony of Drs. Jarrett (A. 467); and Miles (A. 250).

[49] "[A] normal part of training that [mental health professionals are] taught is to look at things in terms of the complex system of dynamics in which people function." * * * "I really can't imagine a more extensive information system, gathering system, than we have now in dealing with families [or] . . . information that can be presented within a couple of hours of a hearing that's going to be of any significant help to me, except in very rare cases." Testimony of Dr. John Filley, (A. 751), (A. 780).

Indeed, this Court itself has recently expressed a similar opinion that appointment of attorneys or other adult representatives would not be necessary, "since the appointed representative's inquiry into the best interests of the child would essentially duplicate that already conducted by the agency. . . ." *OFFER*, *supra*, 97 S. Ct. at 2114, n. 59.

On the other hand, each of the superintendents of the State mental health facilities, as well as other witnesses, questioned about the subject, stated that he would be opposed to any type of judicial proceedings to determine whether a child should be hospitalized. Their reasons were varied, but they centered around the facts that (1) a judicial hearing could not add any more factual information than the hospital could obtain on its own, and (2) the adversarial nature of the hearing would detrimentally affect the mentally ill child[50]. One of Appellants' witnesses, Dr. John Filley, a child psychiatrist, testified that such a proceeding would be quite disruptive. The doctor noted that:

> "[G]oing to the hospital because you have something wrong with you is not that strange. Most kids, as they grow up, know and have found out that you go to a hospital because you have something wrong with you and consult with a doctor, and that seems to be the best thing to do. . . . Due process proceedings in the court, witnesses and so on are much more alien in a child's life and airs all the dirty linen, not all of it probably, but it airs a significant amount of dirty linen in the child's life and parents' lives." [51]

[50] "[I]t's my opinion that where mental illness exists, that physicians and staffs of community mental health centers are trained and experienced in recognizing those conditions, and that the subjecting of a mentally ill child to a courtroom procedure could be detrimental to [him]—could cause him anxieties and tensions, fears, that in my opinion would not be necessary." Testimony of Dr. Lawson Bowling, (A. 366). *See also*, testimony of Drs. Miles, (A. 261); Kuglar, (A. 568); Mazur, (A. 487); Craig, (A. 530-31); and Gates (A. 293-94).

[51] Testimony of Dr. John Filley, (A. 756). Notably, the children's primary witness, Dr. Eli Messinger, who testified concerning the benefit of such a proceeding, had to admit that he had never experienced an adversarial proceeding involving a child such as that contemplated by the district court's order. (A. 216).

Similarly, other people intimately familiar with the processes of the juvenile court concurred with the Appellants' witnesses. As one judge noted:

> "Adversarial hearings in the juvenile courts are often emotionally traumatic. Placing a parent and a child in an adversarial situation when in fact they do not wish to be adversaries, and when in fact the parent is only seeking the best for his child, would, in my opinion, harm the family relationship." [52]

Therefore, the evidence clearly demonstrates that the procedural safeguards sought by the children would not improve the determination of whether a child should be placed in a mental hospital for treatment for his mental illness, and the evidence in fact indicates that the contrary may well be true: that forcing parents to proceed through adversarial hearings in which they are pitted against their child may result in (1) delay by parents in seeking mental health treatment for their child beyond the time which they do now[53]; and (2) compounding the child's existing problems by forcing him to engage in an adversarial hearing, irrespective of whether he desires to do so.

On balance, therefore, it is unlikely that any of the additional safeguards sought by Appellees would materially enhance the protections given to children under the present administration of the challenged statute, and in the absence of some affirmative showing of the benefit flowing from the addition of such procedures, it is evident that the district court erred in holding that such procedures are necessary.

[52] Affidavit of Judge Romae T. Powell, (A. 924).

[53] "There might be quite a number of parents who would not want to get into that sort of a situation [adversarial hearings], but who would be able to work quite effectively with a hospitalization and return after a period of treatment. . . ." Testimony of Dr. John Filley, (A. 757).

C. The benefits of imposing additional due process procedures would not justify the burden placed on the State by such procedures.

As was noted in Argument III B, *supra*, there is a serious question as to whether the additional procedures advocated by the Appellees would not in fact prove detrimental to the children. There is no question, however, as to the costs of such safeguards to the State. As this Court noted in *Ingraham v. Wright*, *supra:*

> "Hearings—even informal hearings—require time, personnel, and a diversion of attention from normal school pursuits. School authorities may well choose to abandon corporal punishment rather than incur the burdens of complying with the procedural requirements." 51 L.E.2d at 736.

Similarly, the imposition of the additional safeguards sought by the Appellees in the present case will impose substantial burdens on the State. In most instances attorneys will have to be provided for the children involved. Under the Juvenile Court Code[54] parents may have to be provided with an attorney if there is any possibility that the parents' rights with respect to the child may be affected. Hospital personnel will be required to leave their duties at the hospital to travel to these hearings, with the concomitant loss in time available to serve the hospital's patients.

Finally, the evidence indicates, notwithstanding the district court's findings to the contrary, that two of the judges of the juvenile courts of Georgia's most populous counties perceived the district court's order as imposing

[54] Ga. Code Ch. 24A-41 provides that if the challenged statute is stricken, further admission of children to hospitals will be accomplished through the juvenile courts. *See* App. A to this brief.

a substantial burden on the operation of their courts. More particularly, while the statistics utilized by the district court seem to obviate the danger of any great burden being placed on the juvenile courts, the judges, who are most knowledgeable as to the ability of their courts to handle additional hearings for mentally ill children, provided evidence that their courts were overcrowded[55], that their facilities and personnel were neither equipped nor trained to deal with mentally ill children[56], and that the burden of such hearings would clearly outweigh the benefits which would be received by the children. Such evidence should not be treated lightly when this Court considers the impact of the district court's order on the State.

This Court concluded, in *Ingraham v. Wright*, *supra*, that:

> "In view of the low incidence of abuse, the openness of our schools, and the common law safeguards that already exist, the risk of error that may result in violation of a schoolchild's substantive rights can only be regarded as minimal." *Id.* at 737.

Substantially the same conclusion is dictated by the record in the present case. To hold otherwise will only result in an imposition on the rights of parents and a diminution of State resources, all in order to obtain additional procedural safeguards which most agree will be harmful to the very children the Appellees say they wish to protect.

[55] Affidavit of Judge Romae T. Powell, (A. 919).
[56] Affidavit of Judge Dennis F. Jones, (A. 930).

IV. IF A PARENT OR GUARDIAN OF A MENTALLY ILL CHILD SELECTS, WITH THE ASSISTANCE OF A PHYSICIAN, A STATE MENTAL HEALTH FACILITY AS A SUITABLE PLACE FOR THE CHILD'S TREATMENT, THE STATE SHOULD NOT BE PROHIBITED FROM PROVIDING THAT SERVICE MERELY BECAUSE ANOTHER TREATMENT SETTING MIGHT BE "MOST APPROPRIATE".

A. Applying the "less drastic means" doctrine to the providing of treatment to mentally ill children is inappropriate.

As a corollary to its holding that parents and guardians cannot voluntarily admit their children to State mental health facilities, the district court also concluded that each mentally ill child must be treated in the setting considered "most appropriate" to his condition.

The court noted that there were many[57] alternative treatment settings which conceivably might be appropriate for mentally ill children, but left the selection of the optimal, "less drastic form of care for these children" to the "professional judgment of the defendant psychiatrists."[58] With this brief allusion to the "less drastic means" theory[59] the district court has expanded a care-

[57] *E.g.*, small group crisis home; small group home; specialized small group living home; small group home clustering; therapeutic camp life; specialized foster parent program; rotating parent program; home care services; and private child care agencies. Opinion of the District Court, Juris. St. 54a.

[58] *Id.*

[59] Commentators use various labels for this theory such as the principle of the "least restrictive alternative" [*see, e.g.*, Chambers, *Alternatives of Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 Mich. L. Rev. 1107 (1972)]; principle of "less drastic means" [*see, e.g.*, Note, *Less Drastic Means and the First Amendment*, 78 Yale L. J. 464 (1968)]; or as the principle of "reasonable alternatives" [*see, e.g.*, Wormuth and Mirken, *The Doctrine of Reasonable Alternatives*, 9 Utah L. Rev. 254 (1964)]. However, since this Court has not settled on a particular designation, Appellants believe it to be more accurately framed in reference to the "most appropriate" setting.

fully tailored constitutional doctrine in a fashion not contemplated by other courts.

The legal theory upon which the "less drastic means" doctrine is predicated is quite simple. It is based on the principle that:

> "[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose." *Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

The "less drastic means" doctrine has been applied to the area of mental health law in two aspects of the involuntary civil commitment process: as part of an inquiry into alternatives to institutionalization[60] and to maximum security treatment within the institution itself.[61] However, the importation of this theory into the complex area of mental health law has not been without dissenters who note accurately that a "court in our legal system is not set up to initiate inquiries and direct studies of social welfare facilities or other social problems."[62] Not only is this theory subject to criticism in its constitutional dimensions *vis-a-vis* involuntary commitments[63], but care-

[60] *E.g.*, *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966).

[61] *E.g.*, *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

[62] *Lake v. Cameron*, *supra*, at 663 (Burger, C. J., dissenting).

[63] *Compare State v. Sanchez*, 80 N.M., 438, 457 P.2d 370 (1969), *appeal dismissed for want of a substantial federal question*, 396 U.S. 267 (1970) (holding that the state need not consider less drastic alternatives to hospitalization), *with Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1974), on remand 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), on remand, ——— F. Supp. ——— (E.D. Wis. 71-C-602, May 28, 1976) (*contra*).

ful analysis demonstrates that it is totally inappropriate to attempt to twist the doctrine to apply to the voluntary hospitalization of mentally ill children.

All adults share basically the same right to liberty, meaning both freedom from bodily restraint and freedom to choose the direction of their own lives without unwarranted restriction by either the State or their fellow citizens. Any restriction imposed upon an adult can be measured against this single "baseline," and it is this ability to compare the freedom that an adult actually has, with what he could rightfully expect to have, which gives meaning to the "less drastic means" doctrine.

Children, however, do not have the same rights as adults, irrespective of whether the issue is the right to be free from bodily restraints or the right to choose the direction of their lives. As noted previously, children clearly have only a limited liberty right *vis-a-vis* the State, having been limited, for instance, in the things which they may read[64], and the things which they may do[65]. It is settled, as this Court held in *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944), that "the power of the state to control the conduct of children reaches beyond the scope of its authority over adults. . . ."

Importantly, not only is a child subject to different restrictions by the State, but he is also subject to restrictions imposed by his parents, as discussed in *Argument I*.

As a result, one child may at his parents' discretion go to an "open school" with almost no restrictions on his physical or mental development. Another child may be forced to attend a military school, where from ages six

[64] *Ginsberg v. New York*, 390 U.S. 629 (1968).
[65] *Prince v. Massachusetts*, 321 U.S. 158 (1944).

to eighteen the child is continuously subjected to "locked doors and windows, regimented routine and institutional hours."[66] Similarly, some children have their own rooms at home, while others are forced to share a room with one, two, or more persons. The list of illustrations is limited only by a parent's imagination, his philosophy of child rearing, his resources, and as noted, certain State laws.

The point, of course, is that there is no "baseline" which may be applied to measure a child's right to be "free" of restrictions, because, leaving aside child abuse, there is no generally accepted concept of what restrictions may be placed on a child. Without a point from which to measure the deprivation imposed by a restriction, the doctrine of "less drastic means" becomes useless and meaningless.

Any attempt to apply this doctrine demonstrates the truth of the Appellants' contention. Who would argue that J.L. and J.R., at the ages of six and seven, should have had the freedom to do as they pleased. These children, like most children, undoubtedly did what their parents or guardians directed them to do. They got up in the morning when they were told, they ate when they were told, they went to bed when they were told. To try to articulate a standard or norm out of this, which can be used as a basis for the application of the "less drastic means" doctrine, is to ignore reality.

Even if the "less drastic means" theory could be articulated in such a manner as would allow it to be applied to children, the facts contained in the record would not support such an application in the present case.

[66] Opinion of the District Court, Juris. St. 48a.

The district court found (based on information provided by the Appellants[47]) that some of the children in the class could be treated in other settings which were characterized as "most appropriate." The district court inferred from this that each different treatment setting represented a less drastic setting for the child than the preceding setting. However, there is no substantial evidence to establish the validity of the district court's conclusion that "most appropriate" is synonymous with the least amount of bodily restraint on the child. In fact, both the evidence and common sense dictate to the contrary.

Certainly the district court assumed, and this is an assumption perhaps shared by others, that institutions severely restrain a child's freedom; that the child can only venture forth when accompanied by an attendant; and that the child is routinely kept behind locked doors. However, the testimony before the district court indicated that institutions place only those physical restraints on a child which are dictated by the child's condition. As Superintendent Mazur noted about the children:

> "They may go to the stores and take bike rides on the campus. . . . They may sign out for an unescorted walk, have weekends or longer than twenty-four hour passes, may go to the snack bar unattended, and so on." (A. 484).

Similarly, when questioned about the restrictions imposed upon children in the hospital setting, Dr. Wayne Hodges, one of the Appellees' witnesses, testified:

> "They do have activity therapy and they are given an opportunity to go out on a daily basis. This is determined partly by the particular problem of the individual and the amount of ward help available for

[47] Opinion of the District Court, Juris. St. 21a.

> monitoring the children. But at least as it is set up all of them have an opportunity to go out if their behavior and the circumstances let them go out." (A. 37).

In short, close supervision and physical confinement, if any, are predicated on the child's individual condition, not on the district court's characterization of the treatment setting as "drastic" or "less drastic."

The record simply does not support a conclusion that any of the treatment settings typically involve more or less bodily restraint than any other. Obviously the restraints in any type of treatment setting cannot be characterized by generalizations, since the restrictions in each instance will depend chiefly on the nature and attitudes of the persons having control over the child, whether it be a foster parent or a house mother in a group home or hospital. To say that different treatment settings vary absolutely in the magnitude of the restrictions imposed upon the children is to ignore both the facts in the record and human nature.

One additional issue should be considered in evaluating the validity of the district court's order directing that the children be placed in a "less drastic" setting. In addition to the traditional freedom from bodily restraint recognized by the courts, the district court also found that children have a more general constitutional right to liberty, which includes the freedom to "be a normal child in a normal household cared for by normal parents."

The Appellants do not quarrel with the ideal of every child being normal, and living in a normal household with normal parents, so long as this does not mean that the State is to establish and enforce a single correct lifestyle. Unfortunately, the truth of the matter is that not every child is, or can be, normal, however that elusive term

might be defined, nor can every household and parent be normal. The district court's goal is perhaps socially desireable, but it is not a constitutional right recognized by this Court. *Cf. Maher v. Roe*, _____ U.S. _____, 45 U.S.L.W. 4787 (No. 75-1440, decided June 20, 1977). Furthermore, a right to be "normal" should not be recognized if, as here, its practical effect will be to deny a child needed treatment.

Therefore, to the extent that the district court attempted to apply the "less drastic means" doctrine based on the concept that the child's "liberty" was being affected, either by the imposition of unwarranted bodily restraints or upon some notion that a child has a constitutional right to be normal, such decision is erroneous and must be reversed.

B. Requiring that mentally ill children be treated only in "most appropriate" treatment settings will deny care to mentally ill children.

In applying the "less drastic means" doctrine to the providing of treatment for mentally ill children, the district court interchanged the concept embodied in the "less drastic means" doctrine with the district court's own theory that children must be treated in the "most appropriate" treatment setting. In Part A, the Appellants demonstrated that the two concepts are not interchangeable, and that the "less drastic means" doctrine has no applicability in the present case.

This leaves the issue of whether the district court's creation, the requirement that mentally ill children be treated in the "most appropriate" treatment setting, has any viability. It is the Appellants' contention that it does not, for it has no support in law and is wholly illogical in practice.

In response to requests for care from persons who are mentally ill, but not ill to the degree which would require involuntary commitment to a State mental health facility, the State of Georgia maintains essentially one type of facility which is available to all who meet certain minimum qualifications. As a result, some people, young and old, may be receiving care in settings which are not "most appropriate." However, it does not follow that by only providing what, in some circumstances, constitutes minimal care, that the State has unconstitutionally deprived the persons using these facilities of their rights. *See Dandridge v. Williams*, 397 U.S. 471 (1970).

In *San Antonio School District v. Rodriguez*, 411 U.S. 1 (1973), this Court had before it the issue of whether it was constitutionally permissible for a state to create a school system and finance it in such a manner that one school district provided only a minimal level of education while other districts provided facilities and personnel which far exceeded this minimal level. The viability of the district court's decision here, finding a supposed right to be treated in nothing other than a "most appropriate" facility, can be illuminated by a consideration of the facts and decision in *Rodriguez*.

In Texas every child was compelled, by a compulsory school law, to attend school. The child was subjected to control by teachers who told him what to do and when to do it, and who could under the Constitution inflict corporal punishment for disobedience. *See Ingraham v. Wright, supra.*

No doubt any number of these children would be characterized as "involuntary" scholars, using the district court's analysis in the present case. Under the district court's holding here, those children would be entitled to

nothing less than the "most appropriate" school setting. We submit that such a holding would be irreconcilable with the actual decision of this Court in *Rodriguez*, and thus the district court's analysis is fatally flawed.

The district court's decision is not legally sound; neither is it logical. Just as the children involved in this Court's decision in *Rodriguez* are not constitutionally entitled to the best, neither are the children involved in this case; however, that is precisely what the district court has mandated, directing that:

> "The defendants shall further spend such money of the State of Georgia as is reasonably necessary to provide such non-hospital facilities and personnel and to place these children in such non-hospital facilities."[68]

The district court made it clear that if the State is to continue providing services to children, it will be required to shape for each child, the treatment setting which is "most appropriate" for that child, irrespective of the cost or the current availability of that particular setting.

The result is that some mentally ill children would necessarily be denied treatment. To illustrate, as this Court noted in *OFFER, supra*, 97 S.Ct. at 2106, n. 40, sometimes "[q]ualified foster parents are hard to find," and even when money is available, few people volunteer to care for emotionally disturbed children[69]. Thus, if a child needs treatment, and if the responsible person, whether it is the hospital personnel or even a court, determines that the "most appropriate" treatment setting

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[68] Opinion of the District Court, Juris. St. 54a.

[69] In the eight-county area surrounding Baldwin County, where J.L. was located, funds were allocated for a specialized foster home for over a year, but the State could not find a couple to fill the position. Testimony of Ann Etheridge, (A. 681).

is a specialized foster home, then no other place will do. It makes no difference that the treatment could be rendered in a hospital or a group home; that would not be "most appropriate."

This result should be abhorrent to everyone who can perceive what it portends. It means that two persons, one a child, and the other an adult, both suffering from the same mental illness, cannot get the same treatment. The adult, because of his majority, can accept the treatment setting which the State provides, even though it may not be the "most appropriate" setting because he is legally able to assume the risks, if any, attendant upon that decision. On the other hand, the district court has decreed that parents, physicians, and even courts are incapable of correctly deciding that these risks may be assumed by a child.

The result of applying the concept created by the district court is that mentally ill children will be the victims of discrimination which they do not deserve and cannot avoid. Such a result—that some mentally ill child must be denied treatment—will be as tragic in practice as it is unsupportable in theory.

CONCLUSION

For the foregoing reasons, the Appellants respectfully urge this Court to reverse the decision of the lower court.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, R. Douglas Lackey, one of the attorneys for the Appellants herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served opposing counsel in this action with three copies of the foregoing Brief of Appellants, by depositing three copies of the same in the United States mail, with first class postage prepaid, addressed as follows:

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This ____ day of August, 1977.

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APPENDIX "A"

Chapter 24A-41

Mentally Ill and Mentally Retarded Children

24A-4101. Purpose. The purpose of this Chapter is to provide an alternative method of securing hospitalization for mentally ill and mentally retarded children. The General Assembly of Georgia herewith specifically recognizes and states that the method of seeking hospitalization for mentally ill and mentally retarded children set forth in this Chapter is cumulative and is not to be used in lieu of present methods of providing treatment for mentally ill children either under this Title or under Code Chapter 88-4, 88-5 and 88-25, but it is only to be used in the event that these other methods are not available. The General Assembly specifically recognizes that the Juvenile Court may make disposition of mentally ill and mentally retarded children utilizing Code section 24A-2601 in appropriate cases, and recognizes the primary jurisdiction of the Juvenile Courts over the commitment of mentally ill and mentally retarded children who meet the standards and criteria found in Code Chapters 88-4, 88-5 and 88-25.

24A-4102. Emergency Receiving Facilities. Any person or other entity having legal custody, or physical custody if the legal custodian cannot be contacted after a diligent search, of any child under 17 years of age who believes that that child may be suffering from mental retardation or mental illness, and is in need of immediate medical attention, may cause the child to be taken to and examined at any emergency receiving facility in this State as defined in Code Title 88. If the physician in responsible charge at the emergency receiving facility believes that the child is mentally ill or mentally retarded, is in need of immediate medical attention, and is in need

of hospitalization, the child may be admitted to the emergency receiving facility, but not otherwise.

24A-4103. Notice. Whenever any child is brought to any emergency receiving facility pursuant to this Chapter, notice shall be given immediately to the child's parents, guardian or legal custodian in the most expeditious manner possible or if there be none, then, irrespective of whether the child is alleged to be mentally ill or mentally retarded, the procedures contained in Code section 88-502.15 shall be used to appoint representatives or a guardian ad litem for the child.

24A-4104. Petition. If any child is admitted to an emergency receiving facility, the person seeking the admission shall, within 24 hours after the admission of the child, excluding Saturdays, Sundays and holidays, cause a petition to be filed with the juvenile court in the county of residence of the child. If the person filing the petition does not know and is unable with reasonable diligence to determine the actual county of residence of the child, the county in which the emergency receiving facility is located shall be deemed to be the county of the child's residence for the purpose of this Chapter. The petition shall be verified and may be on information and belief. It shall set forth plainly:

(a) The facts which bring the child within the jurisdiction of the court.

(b) The facts which led the person filing the petition to believe that the child is either mentally ill or mentally retarded, and in need of hospitalization.

(c) The petition shall have attached thereto a statement of a physician stating that he has examined the child within the past 5 days and setting forth the nature

and results of the examination which led the physician to believe that the child is mentally ill or mentally retarded, in need of immediate medical attention, and in need of hospitalization. Provided, however, a physician's certificate, containing the same information referenced above, obtained at the emergency receiving facility described hereinbefore will meet this requirement.

(d) The names and residence addresses, if known to the petitioner, of the parents. guardian or custodian of the child and of the child's spouse, if any. If none of the child's parents, guardian or custodian resides or can be found within the State or if their respective places of residence addresses are unknown, the name and residence address of any known adult relative residing within the county, or if there be none, the name and residence address of the known adult relative residing nearest to the location of the court; or if there be none, the representatives as defined in Code section 24A-4103.

(e) The place where the child is being kept at the time of the filing of the petition.

24A-4105. Filing of Petition. If the person who sought admission to the emergency receiving facility for the child does not file the petition required by Code section 24A-4105, within 24 hours, the superintendent of the facility in which the child is located shall do so. The filing of the petition by the superintendent of the facility shall occur within 48 hours of the child's admission to the emergency receiving facility excluding Saturdays, Sundays and holidays. The juvenile court in which the petition is filed shall, within 3 days of the filing of the petition, excluding Saturdays, Sundays and holidays, cause a hearing to be held to determine whether there is probable cause to believe that the child is mentally ill or mentally retarded and in need

of hospitalization. This hearing and the hearing required by Code section 24A-4107 may be held concurrently so long as the hearing is held within 3 days of the filing of the petition.

24A-4106. Hospitalization of the Child. During the time after the child is admitted to an emergency receiving facility, the child may be kept at any approved facility, or institution as that term is defined in Code Chapters 88-4, 88-5, or 88-25; provided that notice is given to the parents, guardian, legal custodian, or representative of the child, as to the child's location.

24A-4107. Summons. (a) After the petition has been filed the court shall fix a time for a hearing thereon which shall be not later than 10 days after the filing of the petition. The court shall direct the issuance of a summons to the parents, guardian or other custodian, a guardian ad litem, or any other persons as appears to the court to be proper or necessary parties to the proceedings, requiring them to appear before the court at the time fixed for the hearing. The summons shall also be directed to the child if the child is fourteen or more years of age. A copy of the petition shall accompany the summons unless the summons is served by publication in which case the published summons shall indicate the general nature of the allegations and where a copy of the petition can be obtained. The summons shall be served in accordance with Code section 24A-1702, but if service must be obtained by certified mail or by publication the ten-day period in which the hearing is to be held shall be tolled pending the service of the summons.

24A-4108. Conduct of Hearings. All hearings shall be conducted in the same manner as set forth in Code Chapter 24A-18.

24A-4109. Rights. All persons shall have the same rights in any proceeding under this Chapter as they would have in a deprivation proceeding conducted under the provisions of Code Title 24A, specifically including the provisions of Code section 24A-2101. Further, the child shall have a right to seek a writ of habeas corpus and to apply to the juvenile court for a protective order if necessary.

24A-4110. Findings and Disposition. (a) After hearing the evidence on any petition alleging that a child is mentally ill or mentally retarded and in need of hospitalization, the court shall make findings as to whether the child is in fact mentally ill or mentally retarded and whether the child is in fact in need of hospitalization. If the court finds that the child is not mentally ill or mentally retarded, or that, if mentally ill or mentally retarded, the child is not in need of hospitalization, the petition shall be dismissed and the child shall be discharged from the facility. It is expressly provided that the dismissal of a petition under this Chapter shall not bar any proceeding initiated under any other section of this Code Title.

(b) If the court finds that the child is in fact mentally ill or mentally retarded and is in need of hospitalization, in the absence of an agreement between the concerned parties, which agreement is approved by the court, the court shall immediately commit the child to the Department of Human Resources for hospitalization at a facility or institution to be determined by the Department of Human Resources. The child shall remain under the jurisdiction of the Department of Human Resources only so long as the child continues to need to be hospitalized or until the order of the juvenile court expires, whichever is earlier. The order of the juvenile court shall expire 6

months from the date it was entered, but may be, after hearing, extended for an additional 6 months and as many times thereafter as may be necessary.

24A-4111. Hospitalization. To find that a child is in need of hospitalization, it must be determined that the child is mentally ill or mentally retarded and that the child's illness or condition can most appropriately be treated in a hospital setting. Any child who is mentally ill or mentally retarded but who can be treated most appropriately in an available less restrictive setting may not be hospitalized under this Chapter.

24A-4112. Children in the Custody of the Department of Human Resources. In the event that it is determined, by a court or otherwise, that any child presently or hereinafter hospitalized in any facility in the State of Georgia has been placed in such facility through a procedure or pursuant to a law which is determined to be invalid, the person or persons in responsible charge of the facility in which the child is hospitalized shall herewith be authorized to file a petition in the juvenile court of the child's residence alleging that the child is mentally ill or mentally retarded and in need of hospitalization in the same manner as though the child had been brought to the facility as provided in Code section 24A-4102. After such petition is filed, the issue of whether the child is to remain hospitalized shall be determined as provided in this Chapter.

Supreme Court, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1690

T.M. "JIM" Parham, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W.T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J.L. AND J.R., Minors, Individually and as representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA

BRIEF FOR APPELLEES

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1690

T.M. "JIM" Parham, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W.T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J.L. AND J.R., Minors, Individually and as representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA

BRIEF FOR APPELLEES

OPINION BELOW

The opinion of the district court is reported at 412 F. Supp. 112. The order of the district court denying appellants' motion to stay is reported at 412 F. Supp. 141.

JURISDICTION

The jurisdictional requisites are adequately set forth in the Brief of Appellants.

QUESTIONS PRESENTED

1. When a parent or guardian requests that the state (through the admitting physician at a state mental hospital) make a decision to admit and detain their child in a state mental health facility, there is sufficient "state action," including subsequent action by the state mental health facility, to implicate the Due Process Clause of the Fourteenth Amendment.

2. Whether a statute which allows the state upon application of a parent or guardian to admit and detain a child in a state mental institution for an indefinite period of time without any prior procedural safeguards is violative of the Due Process Clause of the Fourteenth Amendment, and is therefore unconstitutional.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The constitutional and statutory provisions involved are adequately set forth in the Brief of Appellants.

STATEMENT OF THE CASE

On October 24, 1975, two minors, J.L. and J.R., filed a class action complaint pursuant to 28 U.S.C. §1343(3) and 42 U.S.C. §1983 in the United States District Court for the Middle District of Georgia on behalf of "all persons younger than 18 years of age now or hereafter received by any defendant for observation and diagnosis and/or detained for care and treatment at any 'facility' within the State of Georgia pursuant to 1969 Georgia Code Annotated §88-503.1" [A. 49] The plaintiffs requested that the district court declare Ga. Code §88-503.1 unconstitutional as violating the due process clause of the Fourteenth Amendment, and to enjoin its enforcement.

A parent or guardian, pursuant to Ga. Code §88-503.1(a), can request that the state make a decision to admit and detain a child in a state mental health facility for observation and diagnosis for an unlimited period of time. If found to have evidence of mental illness and to be suitable for treatment, formal detention can exist for an indefinite period of time. Children placed in this fashion are designated as "voluntary" patients by the statute. J.L. and J.R. had each been detained in excess of five years.

On November 15, 1975, a three judge court was convened pursuant to 28 U.S.C. §§2281, 2284, and heard oral argument on the legal issues. On November 17, 1975, the class as defined above was certified by the district court. Oral testimony was taken by deposition of 23 expert and lay witnesses. The court visited two state mental institutions and reviewed extensive exhibits.

On February 26, 1976, the court issued its unanimous opinion. The court found that applications for hospital admission are in practice made either by parents or county welfare departments as guardians. It then noted a "constellation of disturbances" involving both the child and the parent whenever the parent requests that the state institutionalize the child. Despite the good intentions of many parents, the court concluded that there are a lot of people who still treat mental hospitals as "dumping grounds." 412 F. Supp. at 133, 138.

The observation stage of the admission process results in children being confined or placed in a hospital "behind locked doors." The physicians who decide upon detention "like all humans are capable of erring," and thus, "psychiatrists like parents cannot be given the power to confine a child in a mental hospital without procedural safeguards." 412 F. Supp. at 138.

In practice, the minor child once committed can be released only if the hospital and parent or guardian agree. Due to the absence of alternative placements, a superintendent cannot release a child without willing and able parents; the absence of parents ready to "accept their child is unfortunately a normal situation." 412 F. Supp. at 135.

The state was made aware of these conditions by a report from a Study Commission on Mental Health Services for Children in 1973, but failed to take any action. 412 F. Supp. at 123.

The district court noted that the liberty interest of juveniles in the context of these facts was strikingly similar to the losses sustained by a juvenile in a delinquency proceeding. 412 F. Supp. at 137. The

court rejected the defendant's arguments that the parent and/or admitting physician provide adequate safeguards to prevent unwarranted institutionalization. Instead, it found the statutory scheme provided "absolutely no due process." 412 F. Supp. at 139.

The court did not prescribe the full range of procedural protections that might be required by the due process clause under these circumstances. Rather, it stated only that "traditionally due process includes the right after notice to be heard before an impartial tribunal." 412 F. Supp. at 137. The court found that there were existing state mechanisms through which juveniles could be committed to mental institutions, and which appeared to provide minimal safeguards (Juvenile Court, Court of the Ordinary).

Finally, the court was confronted with the state's admission that there were 46 children [of the approximately 150 in the class] inappropriately confined in state mental institutions, and that this unnecessary hospitalization was causing these children harm. Accordingly, the court found that the state could not continue to confine these 46 children in institutions.

The court specifically retained jurisdiction in order to monitor the progress of the state, and to provide such additional hearings or orders as might be required. 412 F. Supp. at 140.

Following the decision of the court below, the defendants appealed the judgment to this court and made application for a stay pending on appeal.[1] A stay

[1] Pending review by this Court, J.L., one of the named plaintiffs, died. The Court was informed of his death by letter in August, 1976. The death of J.L. does not moot the instant

(continued)

was denied by the lower court, [412 F. Supp. 141], but was subsequently granted by this court on April 5, 1976 [96 S.Ct. 1503]. Probable jurisdiction was noted by this Court on May 31, 1977.[2]

(footnote continued from proceeding page)
action. Since this case was certified as a class action pursuant to *Fed. R. Civ. P.*, Rule 23, the mootness of the named plaintiff does not inexorably require dismissal. Rather, this case falls squarely within the *Sosna v. Iowa*, 419 U.S. 392 (1975) and *Franks v. Bowman Transportation Co.*, 424 U.S. 747 (1976) rationale discussed by the Court in *Kremens v. Bartley*, ____ U.S. ____, 97 S.Ct. 1709 (1977). As in *Sosna*, the district court's certification of the class remains exactly the same. Mootness of the named plaintiff arises solely "due to the inexorable passage of time rather than to any change in the law," and like *Franks*, the metes and bounds of the class remain the same; the named plaintiff is simply no longer within it. *Kremens v. Bartley, supra*, slip. op. at 11. Finally, since the initial class was certified, it has not been effected by any intervening legislation or regulation. It is thus a "properly certified" class that may succeed to the adversary position of a named representative whose claim becomes moot. *Kremens v. Bartley*, citing *Board of School Comm'rs v. Jacobs*, 420 U.S. 128 (1975).

[2] While recognizing that the Statement of the Case is designed to give the Court an overall view of the circumstances of the case and is not designed to set forth arguments of law or fact, there are several assertions made by appellants in their Statement of the Case, which in the interest of presenting an objective Statement of the Case require comment here with further elaboration reserved for the Argument section.

(a) J.L. was not discharged from Central State Hospital in 1972, but he was placed on furlough at that time.

(b) J.R. had four temporary holiday visits to foster homes. These were not regular foster homes.

(c) There was substantial dispute in the trial court as to the extent of and effectiveness of alleged consideration of alternative placements prior to commitment and screening by

(continued)

SUMMARY OF ARGUMENT

The district court was correct in striking down the provision of Ga. Code §88-503.1 relating to the commitment of juveniles to the state's mental institutions because of the absence of even the most basic of the traditional due process safeguards–notice and the right to a hearing before an impartial tribunal.

The liberty interests of a juvenile are implicated in the state's involuntary incarceration of the juvenile in a state mental institution. However, in deciding whether the Georgia statute provides adequate safeguards, it is necessary to look beyond the nature of the child's interest to the potential and actual effects of institutionalization upon the child as well as to the nature and extent of the interests of both the parents and the state.

In addition to the child's interest in being free from unwarranted physical restraints by the state, which is worthy in itself of safeguards, the very nature of incarceration has numerous other damaging effects including: (1) the regimentation of institutional life which creates institutional dependence and robs the child of the very skills which are required for coping with life outside the institution; (2) the inadequacies

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community facilities prior to commitment. Even appellants' own witnesses did not agree on the extent of or effectiveness of these alleged practices.

(d) There was substantial evidence before the trial court relating to the adverse effects on plaintiffs of life within the institution, and the court visited two of these facilities and personally observed these conditions.

and inherent limitations of the institutions themselves; (3) the loss of continuity of relationships during the developmental years when such continuity is so essential; (4) the duration of the confinement, where the average length of confinement for the class as a whole was 248.6 days and for the named plaintiffs was over 5 years for each; and (5) the undeniable, long-lasting effects of the stigma of institutionalization. These effects which follow the decision to institutionalize a child emphasize the necessity for adequate protections to insure that children are not erroneously institutionalized. Certainly, good therapy demands that each of these adverse effects be increasingly minimized for even those who are subject to commitment, but due process safeguards are designed to prevent these effects altogether for those children who are not mentally ill or not in need of treatment.

Appellees readily acknowledge the importance afforded by our system to the basic rights and duties of parents in the upbringing of their children but feel that these interests must be viewed in the context of the realities surrounding the incarceration of juveniles in mental institutions. It is beyond dispute that a significant number of the families involved with state mental institutions are dysfunctional families, and thus there are inherent conflicts of interest between parents and children. Thus, even though it is certainly unfortunate and one can wish it were not so, the fact remains that in these situations the interests of family solidarity are minimal. Likewise, in those situations where the state is the "parent," the interests of family solidarity are not relevant. Finally, even in intact families, where the interests in family solidarity are

significant, the fact remains that the inherent pressures on and tensions within the family in dealing with the emotional problems of the child are often enormous and make the risks of conflicts of interest and erroneous commitment quite significant and reinforce the need for procedural safeguards. The interest of the family is not to be free of the child, but in the solidarity of the family and in assuring that needed and appropriate mental health services are provided which meet their child's therapeutic needs and which do not needlessly damage the child. Appellee does not seek to exclude the parent from a meaningful part in the commitment decision. However, in a situation fraught with uncertainty, potential conflicts of interest, emotional pressures, and institutional biases, appellees do seek to provide an impartial forum where the child's interests and the circumstances may be reviewed independent of these pressures and the presently granted absolute power of the parent and the admitting physician.

This need for impartial review is further strengthened by the inadequacies within the mental health system: (1) the tendency to institutionalize and to overemphasize pathology; (2) the failures in the admissions process to insure that all necessary information is obtained and to insure that the information used in the decision is in some way validated; (3) the lack of standards in the admissions process.

This Court need not reach the issue of what specific, additional due process safeguards might be required. The district court invalidated the Georgia statute because of the absence of even the most fundamental due process safeguards—notice and a hearing before an

impartial tribunal. The court did not feel compelled to explore the precise parameters of these protections or possible additional protections, but instead it pointed to other Georgia statutes which had not been attacked and which could be used by parents and the state to institutionalize children and left it to the Georgia General Assembly to devise alternative procedures if that body deemed them necessary.

The burden on the state of complying with existing state laws for the commitment of children is not substantial. These laws were passed a number of years ago, have been used to commit over one third of the children incarcerated in Georgia's mental hospitals since 1969, and have not proven to be unworkable or significantly burdensome.

Finally, the district court was correct in directing the state to remove 46 children from state mental institutions and place them as soon as reasonably possible in a non-institutional setting chosen by the state. By the state's own admission these 46 children needed to be in a non-institutional setting and were being harmed by continued incarceration. The district court had no other choice. When the state attempts to exercise its *parens patriae* role in confining a child in a mental institution for treatment, it may not harm the very child who is in their care for protection and treatment.

ARGUMENT

I.

WHEN A PARENT OR GUARDIAN REQUESTS THAT THE STATE (THROUGH THE ADMITTING PHYSICIAN AT A STATE MENTAL HOSPITAL) MAKE A DECISION TO ADMIT AND DETAIN THEIR CHILD IN A STATE MENTAL HEALTH FACILITY, THERE IS SUFFICIENT "STATE ACTION," INCLUDING SUBSEQUENT ACTION BY THE STATE MENTAL HEALTH FACILITY, TO IMPLICATE THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT.

By its express terms, the Fourteenth Amendment applies only to deprivations by a state, "That Amendment erects no shield against merely private activity, however . . . wrongful." *The Civil Rights Cases*, 109 U.S. 3 (1883).

The requirement of "state action" has, however, frequently been held to include ostensibly private conduct. *See, e.g., Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961); *Public Utilities Commission v. Pollak*, 343 U.S. 451 (1952). As a rule, such conduct will be designated a "state action" for purposes of the Fourteenth Amendment if the State has, "to some significant extent" *Burton, supra*, at 722, become involved in it. State involvement with ostensibly private conduct need be neither "exclusive or direct."

Before the existence of "state action" within the purview of the Fourteenth Amendment can be

determined, there must be a "shifting of facts and weighing of circumstances." *Burton, supra,* at 722. While no iron-clad test, applicable to every situation, has been formulated for the recognition of "state action," it is clear that in each case, "the crucial factor is the interplay of government and private action." *NAACP v. Alabama,* 357 U.S. 449, 463 45 (1958).

A particularized inquiry into the facts and circumstances surrounding the admission of a child to a state mental health facility in Georgia and the detention of the child after his admission under the challenged statute clearly indicates sufficient state involvement to invoke the protections of the Fourteenth Amendment.

A. Under The Challenged Statute, Placement And Detention Of A Minor In A State Mental Health Facility Involves Sufficient State Action To Implicate The Fourteenth Amendment.

The Georgia statutory scheme creates a vehicle whereby a child may be detained in a state mental health facility upon the application of his "parent or guardian." This detention is the result of a three-step process outlined by the statute and an analysis of this process clearly demonstrates the presence of the requisite state action.

The threshold step in the process involves the decision upon the part of the parent or guardian to involve the state in determining their child's needs and how best to meet them, by making application to the superintendent of a state facility. In the case of the appellee J.R., this decision was made by the Georgia

Department of Family and Children's Services. There can be no dispute that this is a decision which is totally imbued with "state action."[3] *Cf. O'Connor v. Donaldson,* 422 U.S. 563 (1975); *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974); *Dixon v. Attorney General of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971).

In the case of the appellee J.L., the decision to involve the state was made by his parents. This decision was essentially private action reflecting parental frustration[4] and not imbued with any modicum of state action.

The second step in the process which leads to the placement of a child in a state institution is clearly a crucial one which deeply involves the state. Once an application is made, the child is examined by state psychiatrists, psychologists, and social workers to determine whether or not the child shows "evidence of mental illness" and is "suitable for treatment."[5]

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[3] As the district court noted, the hospitalization of children for whom a county Department of Family and Children's Services is custodian generally results from a determination that foster parental care is unavailable or has been tried and found to be unworkable, leaving hospitalization as the only alternative. Opinion of the District Court, 412 F.Supp. at 134.

[4] Opinion of the District Court, 412 F.Supp. at 133-34.

[5] At this point, the discussion will focus on the "state action" analysis of this case where the parents are the initiators of the placement action. Since placement decisions by state or county agencies are themselves "state actions," no further state action need be found. *See, e.g., Smith v. Organization of Foster Families for Equalization and Reform,* ____ U.S. ____, 97 S.Ct. 2094 (1977); *Drummond v. Fulton County Dept. of Family and Children's Services,* 547 F.2d 835 (5th Cir. 1977) (rehearing en banc granted).

As previously noted, parents do not decide whether or not their children should be institutionalized. They merely decide whether or not to ask the state to make a decision as to institutionalization for their child. The determination as to whether or not a child is to be institutionalized is essentially made by the employees of the state's mental health system. As the director of the State's Child and Mental Health Services testified:

> The parent may come in saying, 'I can't handle it any more; do something.' And they say at the hospital or it might be the psychiatrist who says, 'I think hospitalization is indicated.' The parent would agree and that would decide it.[6]

Without this action by the state psychiatrists and employees of the state mental health system, there can be no detention of the child in the state mental health system. It is this participation by the state in the actual detention decision which transforms the essentially private decision of the parents [to involve the state in determining their child's needs and how to best meet them] into governmental action falling within the ambit of the Fourteenth Amendment. It is immaterial for "state action" purposes that the parent's decision to involve the state is a private parental one. This Court has consistently found "state action" where the initiator of challenged activity was a private individual or organization. *See, e.g., Burton, supra; Reitman v. Mulkey,* 387 U.S. 369 (1967); *Public Utilities Commission v. Pollak,* 343 U.S. 451 (1952); *Shelley v. Kraemer,* 334 U.S. 1 (1948); *Nixon v. Condon,* 286 U.S. 73 (1932).

[6] Opinion of the District Court, 412 F.Supp. at 134.

Once the state psychiatrist has determined that a child should be hospitalized, the third step in the process occurs. The parents acquiesce, and the child is then, without further inquiry, placed in a state mental institution. At this point, the interaction between the parent and the state which results in the detention of the child reaches full flower. The state, becomes the active detainer. The state now backs its decision to detain, however wrongful and unwarranted it may have been, with state facilities and funds.

At this point, the state through the statutory scheme has effected the child's detention without any procedural safeguards and has elected "to place its power, property and prestige," *Burton, supra,* at 725, behind the unreasoned private efforts to wrongfully deprive the child of his liberty.[7]

One commentator has pointed out that "at least when the battle lines are clearly drawn between parent and child—and overt state support is invoked by the parent, it makes sense to insist that this parentally-invoked state authority be held subject to the constitutional norms applicable to the police power, and that the state be required to respect children's claims to developing autonomous individuality." Indeed, "the parents' acquiescence in state intervention may itself convincingly establish the need for it."[8]

[7] *See Cooper v. Aaron,* 358 U.S. 1, 4 (1958). (There is "state action" when there is "state participation through any arrangement, management, funds or property"); *Shelley v. Kraemer,* 334 U.S. 1, 20 (1948) (state action, as that phrase is understood for purposes of the Fourteenth Amendment, refers to exertions of state power in all forms.)

[8] Burt, "Developing Constitutional Rights Of, In and For Children," 39 Law & Contemp. Prob. 118, 137-38 (1975).

Appellant fails in its attempt to analogize the state action here to the state action found to be lacking in *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974) and *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972). Both *Jackson* and *Moose Lodge* involve essentially private activities which are merely licensed by the state, and for which the state provides minimal sanctions and services. This case involves an essentially state activity, *i.e.*, the commitment of a child to a state institution through a process which involves the state throughout. The Fourteenth Amendment's protections clearly would not extend to the totally private, non-statutory placement, by parents, of a child into a private hospital. It is a far different matter when parents utilizing a state statute, seek commitment of a child to a state institution for placement or treatment at state expense. *Cf. Cooper v. Aaron*, 358 U.S. 1, 4 (1958). Then, too, unlike *Jackson*, the state is directly involved here with making a decision to institutionalize as to each individual child. In *Jackson*, the decision to terminate utility service belonged solely to the private company that owned the utility.

B. The State Action Present Under The Challenged Statute Is Not Diminished By The "Discharge Upon Application" Procedure.

The State seeks to dilute the nature of its involvement in the detention of the child by referencing the portions of the challenged statute which provide for discharge upon application of the parents.[9] Their

[9] Ga. Code Ann. §88-503.3.

apparent argument is that there is not "state action" in the continued detention of the child because the child may be discharged with his parent's consent at virtually any time. The argument is without merit. Under the statutory scheme under attack, the hospital superintendent is the detainer of the child. The child has a right to leave the hospital only when both the hospital and his parents agree.[10] The illusory possibility that a child may be discharged upon application of the same parents who committed him and upon agreement of the state does not make his or her detention in the state hospital any less a deprivation of liberty by the state nor diminish the state's involvement in the detention.[11]

II.

A JUVENILE HAS A LIBERTY INTEREST WHICH IS PROTECTED BY THE FOURTEENTH AMENDMENT WHEN HE IS ADMITTED AND DETAINED IN A STATE MENTAL INSTITUTION.

This case presents the limited issue of whether a juvenile may be indefinitely and involuntarily confined

[10] Dr. Filley, A. 786.

[11] Even if the hospital seeks to release children on its own, such release is conditioned upon finding parents who are ready, willing and able to accept their child. As the trial court noted, the absence of parents ready, willing and able to accept their child is unfortunately a normal situation. Opinion of the District Court, 412 F.Supp. at 135. It is difficult to perceive how these same parents, who refuse to accept their child when the hospital seeks release will seek to release on their own. As one witness suggested, some still look upon mental hospitals as a "dumping ground." *Id.* at 138.

in a state mental institution pursuant to Ga. Code §88-503.1 without the benefit of Fourteenth Amendment due process protections. Appellees contend that the use of this statute results in a drastic curtailment of the minor's liberty interest without any due process safeguards.

As a result of this course of action, a minor's liberty is drastically curtailed without any due process safeguards.

The nature of the "interest at stake"[12] is the juvenile's right to be free from unwarranted physical confinement as one of the most basic aspects of constitutional liberty. *Arnett v. Kennedy*, 416 U.S. 134, 157 (1974). Commitment to a mental institution involves a massive curtailment of liberty, *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), which necessitates the imposition of procedural due process safeguards. *See O'Connor v. Donaldson*, 422 U.S. 563, 580 (1972) (Burger, C. J., concurring). The state, acting alone, is constitutionally prohibited from restricting an adult's liberty by commitment unless such action is accompanied by procedural due process. Similarly, this Court has held that a state may not deprive a minor of his liberty in a juvenile delinquency proceeding without due process safeguards; notwithstanding the state's role as *parens patriae* and its claims that such action was in the child's best interest. *In re Gault*, 387 U.S. 1 (1967).

Ten years have passed since this Court announced that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone," and rejected the notion that "the basic rights of a juvenile is not to liberty but to custody," *In re Gault*, 387 U.S. 1, 13, 17 (1967).

[12] *Board of Regents v. Roth*, 408 U.S. 564, 570-71 (1972).

The Court has held in that time that the liberty interest of juveniles is implicated in questions involving juvenile delinquency proceedings (*In re Gault, supra; In re Winship*, 397 U.S. 358 (1969); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1970); *Breed v. Jones*, 422 U.S. 519 (1975)); suspension from school (*Goss v. Lopez*, 419 U.S. 565 (1975)); abortion (*Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976)); and corporal punishment by school authorities (*Ingraham v. Wright*, ____ U.S. ____, 97 S.Ct. 1401, 1414 (1977)).

Thus, it seems evident that where a juvenile is incarcerated by the state in a state mental institution that a *de minimis* level is far surpassed and Fourteenth Amendment liberty interests are implicated.

III.

THE SEVERE DEPRIVATIONS FACED BY AN INSTITUTIONALIZED JUVENILE WHEN VIEWED IN LIGHT OF PARENT/CHILD CONFLICT, AND THE UNRELIABILITY OF PSYCHIATRIC DIAGNOSIS REQUIRE THE MINIMAL DUE PROCESS SAFEGUARDS ENUNCIATED BY THE DISTRICT COURT.

This Court has identified three factors which must be considered against the background of "history, reason, [and] the past course of decisions" in determining what constitutes due process in a particular situation:

> Identification of the specific dictates of due process generally requires consideration of three distinct factors: first, the private interest that will be effected by the official action; second, the risk

> of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

Mathews v. Eldridge, 424 U.S. 319, 335 (1976); *see also Ingraham v. Wright*, ____ U.S. ____, 97 S.Ct. 1401, 1414-15 (1977).

Appellee would pause to emphasize at the outset of this discussion that while the underlying interest set forth in the *Mathews v. Eldridge* test are quite germane and the test is helpful to a point, the district court never had to reach the issue of the full range of the "specific dictates of due process." The district court, after finding the Georgia statute (Ga. Code §88-503.1) constitutionally defective, found that other Georgia statutes for the commitment of juveniles to mental institutions were not attacked, and were still available. Thus, to the extent that portions of the *Mathews v. Eldridge* test suggest a situation where the Court must set forth an analysis of additional safeguards that will be required, the test is not fully applicable. Appellee will examine in detail the interests involved, the risks involved under present procedures, and then present some consideration of the probable value and burdens of the limited due process protections mentioned by the Court, and the impact of using other existing mental commitment laws. Appellee will not attempt to deal with the probable value of and burdens of possible additional formats which may in the future be adopted by the Georgia General Assembly.

A. Confinement In A State Mental Hospital Involves Not Only Physical Restraint But Also Subjection To The Long-Term Adverse Effects Of Institutionalization; Accordingly, The Juvenile's Liberty Interest Is Paramount.

The district court, paraphrasing a portion of this Court's decision in *In re Gault, supra,* aptly described what a child encounters when he is committed to a state mental institution:

> Ultimately, however, we confront the reality of that portion of the mental health process with which we deal in this case. A child is alleged to be emotionally disturbed. The child is admitted to a mental hospital where he may be detained and restrained of liberty for years. It is of no constitutional consequence—and of limited practical meaning—that the institution to which he is admitted and in which he is detained is called a hospital. The fact of the matter is that however euphemistic the title, a regional hospital named Central State Hospital or Georgia Mental Health Institution is an institution known by all as one for the confinement of mentally ill children and adults, in which the child is confined for a greater or lesser time. His world becomes a building with locked doors and windows, regimented routine and institutional hours. Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by psychiatrists, psychologists, social workers, state employees and children who are to a greater or lesser extent, also emotionally disturbed.[13]

In considering the interests of the juvenile, it is beyond question that substantial adverse effects may

[13] Opinion of the District Court, 412 F.Supp. at 137.

result from any commitment to a mental institution.[14] The effects may be physical or mental, may vary in intensity, but their severity is beyond question. The confining nature of the institution, the consequent loss of family, and its replacement by the institution, the indefinite nature of the confinement, and finally the lasting stigma which accompanies the juvenile even after release–these are the realities confronting this Court.

1. Institutional life is regulated, regimented, and repressive.[15]

As in *Gault*, it is claimed that the mental institution does not severely restrict the minor's liberty; that it serves a rehabilitative purpose. In fact, the alleged

[14] While these effects fall upon all juveniles committed to Georgia's mental hospitals, they are especially harsh on children who have no need of incarceration. Neither the state nor the parents have an interest in committing children to institutions who are not in need of institutionalization. Thus, the consequences of incorrect or ill-advised commitment are indeed enormous and because of these enormous risks, every reasonable step to provide reliability should be exercised.

[15] There are distinctions between institutionalization and other forms of medical treatment which are both apparent and sound. Unlike surgery, for example, institutionalization involves a possibly permanent removal of the child from the family home and also a particularly virulent form of stigmatization. And in the case of institutionalization, confinement and deprivation of basic liberties is not merely a *by-product* of the medical procedure (as in the case of an overnight stay or longer for surgery), but rather is the *essence* of the "treatment." Chambers, "Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives," 70 Mich. L. Rev. 1108,

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mentally ill minor is removed from society and placed in a "total institution" in which every aspect of his life is regulated by impersonal authority. E. Goffman, *Asylums*, (1961). Life in a state mental institution is in many ways as routine and regimented as a prison. J. Kate, J. Goldstein and A. Dershowitz, *Psychoanalysis, Psychiatry and the Law* 700-02 (1967).[16]

The difference between a mental institution and a training school can be and appears to be a matter of labels. In 1973, a commission was formed to study mental health services for children and youth in Georgia [hereinafter Georgia Study Commission]. More than half of the minors confined in regional hospitals could be "identified as youthful offenders, except they have not been sentenced." Ga. Study Commission, A. 915.[17] It is not uncommon to find that young people who might be classified as delinquents, subject to due process safeguards, are instead confined in mental institutions.[18]

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1160-61 (1972). No other medical treatment, with the possible exception of sterilization, abortion, and psychosurgery involves so massive a curtailment of liberty and so direct a potential conflict of interest. And even with those forms of treatment, there may be insufficient state action to trigger the protection of the Due Process Clause.

[16] *See Barry v. Hall*, 98 F.2d 22 (D.C. Cir. 1938) (comparison of prison inmate and mental patient).

[17] *See also Bartley v. Kremens*, 402 F.Supp. 1039, 1044 (1975); Dr. Gates, A. 301.

[18] *See* Weiss & Pizes, "'Hospitalizing the Young: Is It For Their Own Good?" 54 *Mental Hygiene* 498 (1970).

The physical restrictions upon life in an institution are also similar to a penal facility. One of the institutions involved in this suit where both named plaintiffs were incarcerated for over five years each, Central State Hospital at Milledgeville, embodies all of these aspects of institutionalization. Milledgeville began its operations in 1842, and was at one time, with over 12,000 inmates, the largest mental institution in the world. Brown, "The Milledgeville Story," 14 Mental Hospitals 582 (1963); A Deutsch, *The Shame of the States* 88-95, 113-14 (1948). The institution has been the subject of recurring scandals of patient neglect and abuse. Brown, *supra;* Deutsch, *supra.* By the time of the hearing in this case, the institution still held 7,523 inmates. 412 F. Supp. at 120.

Each member of the three judge panel inspected this institution, as well as Georgia Regional Hospital, a newer facility in Atlanta.[19] They carefully and thoroughly investigated the nature of the confinement experienced by minors confined in Georgia's mental health facilities.[20]

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[19] Georgia Regional Hospital–Atlanta was operational in 1965, 412 F.Supp. at 119, n.11, and has special programs for children, *see* A. 914-15.

[20] Appellant's characterization that the district court "assumed" there were severe restraints on a minor's liberty ignores the court's personal inspection. Brief of Appellant, p. 48. "On two separate occasions, the three judges of this court have visited two of Georgia's eight regional mental hospitals . . . and witnessed for themselves the facilities in which plaintiffs are confined. During these visits, the court talked at length with the defendants, hospital personnel, and some of the plaintiffs." Opinion of the District Court, 412 F.Supp. at 119.

The rehabilitative nature of such institutions is subject to question. The Study Commission found that the physical facilities at Central State were "decrepit" and at another institution "so poor that very little treatment can be done (only behavior control for adjusting to institutional expectations)." A. 914-15. Unfortunately, many state institutions are understaffed, underfinanced, and overcrowded.[21] Despite an alleged effort to differentiate between minors and adults, in some institutions minors twelve or older are confined on wards with adult patients suffering from a variety of mental illnesses. Ga. Study Commission at C-1; Dr. Bowling, A. 360.[22] Georgia is not alone in this practice.[23]

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[21] See Hobbs, *Futures of Children, supra*, at 127-28: "Overcrowding is commonplace. Many residential facilities have as many as 25 to 50 percent more residents than they were intended to serve. Buildings that are old and poorly designed also create problems. For instance, lavatory and toilet facilities are often poorly maintained and may even be nonfunctioning. Ancient facilities may make it difficult if not impossible to prepare food in a sanitary fashion; and climate control may be so inadequate as to leave buildings either too hot or too cold. Equally inadequate are modern complexes of steel, chrome, and glass, when human caring is absent."

[22] Minors age twelve and over are not subject to any special screening process and are treated as adults. A. 372-73. The reason for this differentiation is supposedly a policy of the appellants. A. 377.

[23] Over fifty percent of all juveniles admitted to state, county and private mental institutions in 1971 were placed on adult wards. *See* Nat. Instit. of Mental Health, *Hospital Inpatient Treatment for Emotionally Disturbed Children, United States, 1971-1972* 1 (1972).

This is not to suggest that Georgia has failed in recent years to make progress in upgrading its facilities and services. However, even the gradual improvement of the system will not end the adverse effects described throughout this section. As one expert witness noted:

> Generally speaking, institutions run in a regimented fashion; they deal with numbers of people, so that procedures, regulations, policies, routines, schedules have to accommodate the needs of the staff in managing large numbers of patients rather than the more specific individual needs of the . . . of any individual person. I believe that *no matter how forward looking and progressive the institution,* there is inevitably some tendency to sacrifice the needs of the individual patient for the needs of institutional efficiency. (Emphasis added).[24]

In addition to poor physical facilities and locked buildings, the regimented routine, noted by the lower court, often substitutes for the rehabilitation alleged to be present in these institutions, and in fact children may become sicker.[25] These factors have led the Joint Commission on Mental Health of Children to conclude:

[24] Dr. Messinger, A. 176-77. Dr. Messinger further elaborated on the immediate and long-term adverse effects of drugs on mental patients; more specifically, the effects on J.L. A. 185. Dr. Filley concurred as to adverse effects produced. A. 762.

[25] "Go to a big state mental hospital in almost any state and ask to visit the children's ward. If you are allowed to visit, you will find people, children and staff alike, caught up in a no-exit game. Patients and staff play their roles, each defined by the other, both prescribed by elaborate regulations and procedures that serve one purpose: to maintain the stability of the institution. Most of these institutions are so large, so unwieldy,

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> Thousands of our children and youth continue to be herded into large, depersonalized institutions where custodial care, rather than remediation, is still the order of the day.

Social Change and the Mental Health of Children (Summary and Recommendations) at 8.[26]

This regimented routine also effects the child's development. Adjustment to a regimented or structured routine can result in a loss of skills to cope with life outside the institution. N. Hobbs, *Futures of Children: Categories, Labels, and Their Consequences,* 135-36 (1974) (notes omitted).[27] Instead the juvenile adapts to institutional life and models his behavior on the inappropriate behavior of other patients. Dr. Wayne

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so antiquated in design, so poorly staffed, so burdened with the miseries of man that everyone involved must devote most of his energies to maintaining a steady-state situation. The metaphor of illness rules. Change in or deviation from role requirements cannot be tolerated. Apathy goes unnoticed. Precise adherence to role expectation is praised and rewarded, while deviations and serious efforts to change the system are punished. In such a setting, hospitals can indeed make children sick." Hobbs, *Futures of Children, supra*, at 130.

[26] *See also* Dr. Dorothy Miller, "Rehabilitation of Mentally Ill Children: A Position Paper;" Joint Commission on Mental Health of Children, *The Mental Health of Children: Services, Research, and Manpower*, p. 48: "public institutions have become 'psychiatric graveyards' or warehouses for many of these children."

[27] This "institutional dependence" combined with the lack of "continuity of relationship" can in itself lead to deliberately intended bizarre behavior. *See* Patient No. 8, A. 896, ". . . this is an institutionalized child who knows all the ways to express craziness and get need taken care of. . . ."

Hodges, A. 22; Ga. Study Commission, A. 904. Both named plaintiffs, J.R. and J.L., suffered from institutionalization as noted by one of the expert witnesses:

> I was especially concerned about the rather lifeless, passive self-effacing tendencies of [J.R.] who did not seem to be able to speak his mind or present his point of view and wishes in a forward and vigorous way. J.L. is obviously clamoring for a home life and asks very explicitly to be taken care of in a family setting, as did [J.R.].

Dr. Messinger A. 184.

Even adolescents who undergo short-term hospitalization can be effected by "institutional dependence." Hobbs, *Futures of Children, supra,* at 135. Since a child's concept of time is different than that of an adult, the effects of being in an institution are incurred much earlier and are more pronounced.[28]

Thus, despite claims that a minor is institutionalized for rehabilitative purposes, the above factors demonstrate that "the fact remains that it is incarceration.

[28] Dr. Messinger, A. 178-79. "The longer the stay in the hospital, the greater the likelihood of what's commonly called institutionalization; that is, acceptance of the kind of routine and regimented life of an institution. However, if a child is in a hospital even for what in our eyes is a brief period of time, those effects can nevertheless be quite damaging for two reasons. One is the child's perception of time is quite different from an adult's perception of time, and a day or a week or a month in the life of a child from a developmental point of view as well as from their subjective point of view is quite different from that duration of time for any of us as adults. Secondly, the stigma, both public and subjective of being in a psychiatric hospital, will be present whether one is in for a day or for a year or five years."

The rehabilitative goals of the system are admirable, but they do not change the drastic nature of the action taken. Incarceration of adults is also intended to produce rehabilitation." *Breed v. Jones,* 421 U.S. 519, 530, n.12 (1975). The adverse consequences of such incarceration on a juvenile are clear—and severe.

2. The juvenile is deprived of the continuity of relationships with family and friends.

The institution becomes the juvenile's entire world; as a result, he loses contact with both his family and community. As psychological authorities have noted, a child's normal development is dependent on the "continuity of relationships" that involvement with a non-institutional environment provides.[29] Even in institutions where care, safety and stimulation may be provided" the institution is ordinarily unable to provide a child with the "environmental influences . . . essential for a child's normal development." J. Goldstein, A. Freud, & A. Solnit, *Beyond the Best Interest of the Child* 21 (1973).

The treatment programs in Georgia state mental hospitals were described as "institutional in character and extremely limited in opportunities for normal childhood experiences." Ga. Study Commission, A.

[29] Dr. Messinger, A. 176; Dr. Mazur, A. 484 ("To remove a child from its home environment is a much more serious step than to remove an adult.")

915.[30] The lack of such normal development was described by Dr. Messinger after visiting with J.L., one of the named plaintiffs:

> One of the things that I noticed about Joey is that he was–he latched onto whoever seemed to offer him what I would call a feeding experience, a nurturing experience, giving experience, at that moment. . . . [I]n an institutional setting because one doesn't have the mother and father to whom one can rely on for nurturance over an extended, really indefinite period of time, one has to make use of whoever is available at the moment. Also, one learns that the good guy or the good woman who might be available today might not be available on the next shift or . . . the next week or month, so one takes what one can when one can. I saw a great deal of that mentality in Joey.

A. 212.

The problem is made more severe, and in fact was so in J.L.'s case, because parents can be reluctant to participate in the treatment of the child or to take their child back.[31] As the district court found, based on the testimony of the state's own professionals, there are parents who "actually abandon their child to the state," 412 F. Supp. at 138.[32] and who utilize state mental

[30] A "big brother or big sister" who is to provide "personalized individual attention" to a minor patient spends 30 minutes a week with a child. A. 342.

[31] *See* Affidavit of Janet Scott, A. 59-61. J.L.'s adoptive mother and stepfather went so far as to attempt to relinquish their rights to J.L. to Central State Hospital (albeit unsuccessfully). A. 104-06.

[32] "The big problem is very often not getting the child well enough to go home, but getting the parents essentially, you know, [to] even take this child. Dr. Kuglar, A. 579.

institutions as "dumping grounds" for unwanted children.[33] Thus, the minor is caught in a vicious cycle, losing contact with both parents and community, producing increased anxiety and the likelihood of longer institutionalization.[34]

The child's interest in remaining as an active member of his family and participant in his community is significant. Just as a parent has an interest in not being "needlessly . . . separate[d] from his family," *Stanley v. Illinois*, 405 U.S. 645, 653 (1972), so does the minor in not being separated by needless confinement in an institution. Opinion of the District Court, 412 F. Supp. at 136.

3. Confinement is indefinite.

The next element to be noted about the effects on the deprivation of juveniles' liberty under the Georgia statutory scheme is its duration. Under the challenged statute, the confinement of the child can last until the child reaches maturity, and there is no provision for meaningful periodic review. The named plaintiffs were each confined for more than five years despite the hospital's recommendations for placement outside the institution as early as 1973.[35] The average length of

[33] Dr. Filley, A. 768.

[34] *See* Reiger, "Changing Concepts in Treating Children in State Mental Hospitals," J. Child Psychotherapy 89, 104 (1972). *See* Ga. Study Comm'n., A. 917.

[35] Although there was a review of J.L.'s case in 1975 [A. 351], it noted only his presence. Despite a statutory requirement that patients be released when no longer in need of

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confinement for the class as a whole was 248.6 days, and at Milledgeville it was 456 days.[36]

4. The stigma of institutionalization effects the minor both during his confinement and after his release.

A minor who is institutionalized can also suffer from "the development of a negative self-concept and vulnerability to rejection by one's peers, as well as the

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hospitalization [Ga. Code §88-503.2], superintendents agreed that release only occurs when there is a willing parent or guardian. If the parent is not available or the state is unable to locate an alternative placement, the juvenile continues to be hospitalized, and thus, a cycle begins. As the child grows older, he is harder to place [412 F.Supp. at 135], and the longer he stays, the more he becomes institutionalized, and the likelihood of placement outside the institution diminishes.

[36] Opinion of the District Court, 412 F.Supp. at 120; *Compare Goss v. Lopez, supra*, 419 U.S. at 576 (ten day school suspension).

The National Institute of Mental Health has reported: "that thousands upon thousands of elderly patients now confined on the back wards of . . . state (mental) institutions were first admitted as children thirty, forty, and even fifty years ago. A recent report from one state estimates that one in every four children admitted to its mental hospitals "can anticipate being permanently hospitalized for the next 50 years of their lives." Joint Comm'n on Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's* (1969) pp. 5-6.

limitations on access to various opportunities."[37] This concept, commonly called "stigma," effects the mental patient both during and after release. It connotes both a sense of shame by the patient and a discriminatory reaction by others and each acts as a cause or effect of the other.[38]

The existence of stigma whether self, social, or both, on ex-mental patients is recognized by a majority of the mental health profession.[39] Courts considering this issue

[37] Hobbs, *Futures of Children, supra*, at 135-36 (notes omitted). Hobbs continues by noting that: "This potential stigma is particularly difficult for an adolescent, whose major task is to develop a coherent sense of identity and a foundation of self-esteem. To find himself the object of fear or distrust or to discover that his chances for employment, admission to college, securing a driver's license, or entering military service are diminished can only be disheartening."

[38] *See* Cumming & Cumming, "On the Stigma of Mental Illness" 1 *The Community Mental Health Journal* 135-36 (1965).

[39] *See, e.g.*, Cumming & Cumming, *supra* at 136-37; Farina, Ring, "The Influence of Perceived Mental Illness on Interpersonal Relationships," 70 J. of Abnormal Psychology 47, 50 (1965) ("believing an individual to be ill strongly influences the perception of that individual; this is true in spite of the fact that his behavior in no way justifies these perceptions."); Miller & Dawson, "Effects of Stigma on Re-employment of Ex-mental Patients," 49 Mental Hygiene 281 (1965); Hobbs, *Futures of Children, supra*, at 26, 34, 143; Dr. Messinger, A. 178; Dr. Mazur, A. 512; It also recognized that the effects of stigma are much greater on members of the lower class, and that this class constitutes a proportionately higher rate of the institutional population. Schwartz, Meyers, and Astrachan, "Psychiatric Labeling and the Rehabilitation of the Mental Patient," 31 Arch. Gen. Psychiatry 329, [illegible] (1974). Even the superintendents of Georgia's regional hospitals recognize stigma as unfortunate, but nonetheless a reality. Dr. Mazur, A. 512.

have also acknowledged its existence and its harmful effect.[40] The necessity to protect this aspect of liberty has also been stressed in cases involving juveniles. *See In re Gault, supra,* 387 U.S. at 23-24; *Breed v. Jones, supra,* 421 U.S. at 530; *Goss v. Lopez,* 419 U.S. 565 (1975).[41] The need for full procedural protections is particularly strong where the stigma of institutionalization is clearly recognized and which some commentators have noted may be more lasting than imprisonment for commission of a crime.

B. Although Parents Have A Right To The Care, Custody, And Control Of Their Children, When They Involve The State In Making A Decision To Institutionalize Their Child In The Context Of The Potential And Actual Conflicts And Pressures Inherent Therein, That Right Is Subordinate To The Juvenile's Liberty Interest.

The minor facing institutionalization is not the only person whose interest is affected, for the parent is also

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[40] *See, e.g., Donaldson v. O'Connor*, 493 F.2d 507, 520 (5th Cir. 1974) *vacated and remanded sub. nom.* 422 U.S. 563 (1975); *In re Ballay*, 482 F.2d 648, 668 (1973); *New York Association for Retarded Children v. Rockefeller*, 357 F.Supp. 752, 762 (N.D. N.Y. 1973).

[41] The constitutional status of stigma as a liberty interest in this case is not negated by this Court's holding in *Paul v. Davis*, 424 U.S. 693 (1976) because that case specifically recognizes the Fourteenth Amendment implications of stigma where the state, by the same stigmatizing action, deprives the individual of other statutory or, as here, constitutional rights.

affected by the change in the child's status. The parent's right "to direct the upbringing and education of children under their control" has long been recognized. *Pierce v. Society of Sisters,* 268 U.S. 510, 532 (1925). However, the state "may restrict the parent's control," [*Prince v. Massachusetts,* 321 U.S. 158, 166 (1944)] if it appears that the parental decision will jeopardize the health or safety of the child, or have a potential for significant social burdens." *Wisconsin v. Yoder,* 406 U.S. 705, 234 (1971). In defining the safeguards required by the Fourteenth Amendment, the weight of the parent's interest must also be examined.

This Court has consistently acknowledged the importance of the doctrines of family privacy, *Moore v. City of East Cleveland,* ____ U.S. ____, 97 S.Ct. 1932 (1977), and parental autonomy, *Meyer v. Nebraska,* 262 U.S. 390 (1923). These interests, assuming they are significantly present at the time a parent seeks institutionalization, are not adversely affected by the requirement of due process safeguards. In some cases, these safeguards will help to maintain this autonomy by increasing the likelihood of appropriate placement or determine that these considerations are no longer relevant because of the dysfunctional nature of the family.

The interest of the parent, whether a dysfunctional or an intact family, is not to be free of the child (except perhaps in respite period circumstances). For one reason, going back home is not the only alternative to institutionalization. Moreover, the parents' interest is not family privacy or family relationship free from intrusion by the state in this context, because it is the

family that has asked the state to remove the child from the home. Specifically, the parents' most legitimate and dominant interest is to obtain the best available and most appropriate mental health care for the child. The same interest is shared by the state in its *parens patriae* role.

Obviously, these interests do not exist where the state as guardian [acting through 159 county Department of Family and Children Services offices (hereinafter DFCS)] acts to institutionalize a minor, such as J.R. In such cases the state may act to institutionalize simply because a social worker determines that foster care is unavailable or unworkable. Gladelle Whitaker, A. 426-434 (a decision to institutionalize by DFCS is not subject to review within the agency or guided by any state policy). This arbitrary deprivation of liberty by the state can only be protected by due process hearings. As Justice Stevens has noted, the status of legal guardians does not give public officials "carte blanche to disregard a child's constitutional rights." *Vann v. Scott*, 467 F.2d 1235, 1240 (7th Cir. 1972).

It is important to examine the context in which the parent decides to apply to the state for institutionalization of a minor. "[I]t's by now a truism built over maybe fifty years of clinical experience . . . that the pathology of children is inextricably related to the pathology of the family. . . ."[42] As a result of their personal, inextricable involvement with the child's (and most likely the entire family's) alleged mental problems,

[42] Opinion of the District Court, 412 F.Supp. at 133, noting testimony of both psychiatrists employed by the state and independent of the parties to the same effect.

the parents may be incapable of rationally deciding what is best for the child or the family; they may simply want to get rid of the child.

Thus, although the child may not suffer from mental illness to the extent requiring institutionalization, he may be:

> . . . a behavior problem or a learning problem or a difficult child for which agencies will not take responsibility, so as the most expeditious bureaucratic maneuver the child is hospitalized; and I think that the case with the two patients that are in question in this case.

Dr. Messinger, A. 170. At another level, family harmony may be disrupted by failures in communication, by honest differences in values, or by the "generation gap," Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions." 62 Cal. L. Rev. 840, 851 (1974).[43] Finally, parents may also unconsciously project onto the child wishes or undesirable characteristics they wish to defend against. Dr. Messinger found an example of such

[43] "Parents may be confused, bewildered, and saddened by what they perceive as their child's crazy behavior. In individual cases there may be some validity to the parents' belief in a connection between acceptance of counter-cultural styles and emotional difficulties, but parents' own visceral reaction to the different lifestyle may color their own diagnosis. Where parental action does result in unjustified commitment, it is probably not due to malevolence or filial hatred but to a feeling more akin to irritation or to embarrassment over the child's unconventional behavior. The level of irritation or embarrassment can become acute and reach a level where parents become desperate." *See also*, B. Ennis and L. Siegel, *The Rights of Mental Patients* 38 (1973); Dr. Messinger, A. 166.

"scapegoating" in the case of J.L., whose mother was concerned about the effect of J.L.'s behavior on her new husband and child. A. 96. As Dr. Messinger described the effect:

> And I think he (J.L.) was, in a sense sacrificed for that marriage to be preserved. It's [scapegoating] rarely seen in that kind of clarity, but it happens in more subtle fashion frequently. . . .

A. 193-94.[44]

With these anxieties and feelings of guilt, the concerned parents consult a state physician, lacking insight into their own problems and unable to objectively evaluate their child's situation. Even loving parents are often unable to accept a child that may be emotionally ill,[45] and thus they readily accept or even desire the opportunity to allow the state to commit the child.

State institutions often see the parent and community, not the patient, as their primary client.[46] Thus the state will institutionalize the juvenile based on the needs of the parent, not the mental health of the child.

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[44] Janet Scott, who was J.L.'s primary out-patient therapist, came to the same conclusion and did not feel institutionalization was required, A. 60; incredibly, the admitting physician did not consult with her prior to J.L.'s admission. A. 61. *See also*, patient number 832-00-2191, A. 894.

[45] Joint Comm'n on Mental Health of Children, *The Mental Health of Children: Services, Research and Manpower, supra*, 280-81; Dr. Bowling, A. 370-71.

[46] Hobbs, *The Futures of Children, supra*, 139 citing Sachoteiff, Steinfield & Tolchin, "The Struggle for Patients' Rights in a State Mental Hospital," 54 Mental Hygiene 230, 239 (1970).

J.L.'s admission to Central State Hospital presents a striking example of this. Dr. Gutierrez, of the Child and Adolescent Unit at Central State Hospital notes that J.L.'s commitment was initiated by his adoptive mother in order to save her second marriage. J.L.'s stepfather had delivered an ultimatum: that she must choose between J.L. and himself. She chose the latter.

Thus, a parent may seek institutionalization due to mental or physical strain, economic hardship, or the competing needs of family members.[47] These are not the results of ill will, but they do reflect the competing interests of the parent and the care needed for an emotionally troubled child. This conflict has been recognized by the court below and several other courts; the complex dynamics of these situations strengthens the likelihood that parents' interests can compete with those of the child. Thus, some sort of impartial hearing is necessary to resolve the varying interests and, in some cases, to assist in preserving the family. *See, e.g., Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968); *Saville v. Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974); *New York Association for Retarded Children v. Rockefeller, supra*, 357 F. Supp. at 762; *Horaeck v. Exon*, 357 F. Supp. 71, 74 (D. Neb. 1973); *In re Roger S.*, 19 C.3d 655 (1977); *In re Lewis*, 51 Wash.2d 193, 200-01, 316 P.2d 907, 911 (1957); *In re Sippy*, 97 A.2d 455, 459 (Mun. Ct. App., D.C. 1953).

In addition to those parents who are concerned, there are, as the court noted:

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[47] Opinion of the District Court, 412 F.Supp. at 134.

> . . . some parents whose abuse that authority and who under the guise of admitting a child to a hospital actually abandon their child to the state.

412 F. Supp. at 138. For these parents, their supposed interest in preserving the family or avoiding the effect of a hearing is inconsequential compared to the loss facing the child.[48]

For some, institutionalization provides a means to continue to deny their involvement with the child, T. Lide, S. Fleck & A. Cornellison, *Schizophrenia and the Family* 274 (1965) and to withdraw from the troubling situation. Ellis, "Volunteering Children," *supra,* 62 Cal. L. Rev. at 863. This withdrawal, as the district court found, may include actually leaving the state.[49]

In 1973, between 50 to 75 percent of the juveniles in Georgia's mental health institutions had no family, were part of severely dysfunctional families, or were in state custody.[50] Nationally, experts conclude that some degree of dysfunctional family units exist.[51] Thus, for

[48] As the Director of Georgia's Office of Child and Adolescent Mental Health Services noted: "[P]roblem here in part is the history and tradition of mental hospitals which have been dumping grounds in the past. As we try to move out of this, there are a lot of people who still treat them as dumping grounds. . . ." Dr. Filley, A. 767-68.

[49] *See, e.g.,* Dr. Miles, A. 259.

[50] This is apparently recognized by the superintendents. For example, Dr. Gates stated that a large percentage of the children coming to his institution come from broken homes. Dr. Gates, A. 284.

[51] J.C.M.H.C., *Mental Health: From Infancy Through Adolescence*, 174 ["... many families are already broken when the child is in placement ... (one study shows only 19 percent of families complete.)"].

many parents the valued goals of parental authority and family unity are substantially weakened at the time application is sought. More importantly, it is parents who initiate the process of having the child removed from the family (by seeking to institutionalize the child) and they who "voluntarily," in approaching the state for assistance, surrender to some extent, their right to family privacy.

This Court has recently dealt with a closely analogous situation involving both the liberty interest of the minor and of the right of parents to raise their children. In *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976), a state statute which gave parents an absolute veto over the right of a minor to secure an abortion was held unconstitutional. The *absolute* nature of combined power of parents and the state in this case is at least comparable to the situation in *Danforth.*

To paraphrase this Court's language in *Planned Parenthood v. Danforth, supra,* it is difficult to conclude that by providing a physician with absolute power to institutionalize a child based upon the application of the parent in the absence of any impartial hearing will serve to strengthen the family unit. Neither is it likely that such power will enhance parent authority or control where the minor and the parent are so fundamentally in conflict and the existence of an emotional disturbance has fractured the family structure.

Unlike *Danforth*, appellees do not seek to completely invalidate the parents' consent. What is sought is only an impartial forum where the problems and needs of

the child can be considered along with the concerns of the parents.[52]

C. The Risk Of Erroneous Deprivation Of The Child's Liberty Is Substantial Since The State's Admission Process Is Inadequate, Lacks Uniform Standards, And Provides No Safeguards On The Unchecked Power Of The Admitting Physician To Institutionalize. Thus, Additional Safeguards Are Required.

"There can be little responsible debate regarding the uncertainty of diagnosis in this field (psychiatry) and the tentativeness of professional judgment." *O'Connor v. Donaldson,* 442 U.S. 563, 584 (1975) (Burger, C. J., concurring) citing in part Justice Frankfurter in *Greenwood v. United States,* 350 U.S. 366, 375 (1956).

The inability to accurately diagnose mental illness is due in part, to a disagreement over what behavior can

[52] The court's opinion in Bellotti v. Baird, 428 U.S. 192 (1976), suggests that a materially different constitutional issue would be presented under a provision requiring parental consent or consultation in most cases but providing for prompt (i) judicial resolution of any disagreement between the parent and the minor, or (ii) judicial determination that the minor is mature enough to give an informed consent without parental concurrence or that abortion in any event is in the minor's best interest. Such a provision would not impose parental approval as an absolute condition upon the minor's right but would assure in most instances consultation between the parent and child.

In *Bellotti, supra*, the court vacated and remanded to allow for state court interpretation of a law which required parental consent for a minor's abortion, but permitted a judge to grant consent for good cause, if the parents refused.

be classified as "mentally ill."[53] Psychiatric judgments are effected as much by the evaluators' training, experience, class, culture, race, sex, and personal biases as by the patients' alleged condition. Ennis & Litwack, "Psychiatry and Expertise: Flipping Coins in the Courtroom," 62 Cal. L. Rev. 693, 719 (1974). In this case, experts testifying on behalf of both parties agreed with these conclusions.[54] Even the language and culture of different regions within the United States can effect diagnostic reliability.[55]

> And, because of the unavoidable ambiguous generalties in which the American Psychiatric Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there.

Livermore, Malmquist & Meehl, "On the Justifications for Civil Commitment," 117 U. Pa. L. Rev. 75, 80 (1968). As a result, minors like J.L. and J.R. are admitted with conflicting diagnoses. Dr. Messinger, A. 174. There is no one to question this conflict or its basis.

[53] Roth, Dayley, & Lerner "Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes," 3 Santa Clara L. Rev. 400, 403 (1973).

[54] Dr. Falek, A. 706; Dr. Messinger, A. 173.

[55] A problem can exist "even when a northerner . . . comes down here and does not understand southern idions." Dr. Filley, A. 765. There are foreign born or foreign trained doctors at all of Georgia's mental health facilities. *See, e.g.,* Dr. Craig, A. 533. At Central State, Spanish speaking doctors with admitted communication difficulties are assigned to the Children's and Adolescent Unit. Dr. Gates, A. 320-321.

1. Psychiatrists have a tendency to overdiagnose mental illness.

Empirical studies have demonstrated that psychiatrists and physicians employed by state mental institutions, recommend institutionalization for persons not in need of confinement.[56] This leaning toward institutionalization is the result of several factors. Psychiatrists, as part of the medical profession, tend to err on the side of caution.[57] Thus, where there is any doubt, institutionalization is preferred. Secondly, psychiatrists think in terms of psychopathology and as

[56] Dershowitz, "Psychiatry in the Legal Process: A Knife That Cuts Both Ways," 4 Trial 29, 32-33 (Feb./March, 1968); Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions," 62 Cal. L. Rev. 840, 363-68 (1974); Ennis & Litwach, "Psychiatry and Presumption of Expertise: Flipping Coins in the Courtroom," 62 Cal. L. Rev. 693, 711-19 (1974); "Commitment," 117 U. Pa. L. Rev. 75, 83 (1968); Rosen, "Detention of Suicidal Patients: An Example of Some Limitation in the Prediction of Infrequent Events," 18 J. of Con Psychology 397 (1954); Note, "The Role of Counsel in the Civil Commitment Process: A Theoretical Framework," 84 Yale L. J. 1540, 1553-54 (1975); *People v. Burnick*, 14 Cal.3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975); *In re Long*, 25 N.C. App. 703, 215 S.E.2d 626, 629 (1975); T. Schief, *Being Mentally Ill: A Sociological Theory*, 104-21 (1966); Bazelon, "Institutionalization, Deinstitutionalization and The Adversary Process," 75 Colum. L. Rev. 897, 900 (1975); Dr. Messinger, A. 172-173; Dr. L'Abate, A. 806.

[57] *See* Ellis, *supra*, at 865-66; Rosen, *supra*, at 385; T. Schief, *supra*, at 105-121.

a result tend to diagnose ambiguous behavior as mentally suspect.[58]

Finally, and equally as important, institutional psychiatrists often lack knowledge of community resources as an alternative to institutionalization.[59]

2. The commitment decision is based upon arbitrary policies and procedures.

The admitting physician's commitment determination is further suspect due to the inadequacy of information upon which his decision is based and the policies of the institution in which he practices. Unlike the physician and minor in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) or the physician and adult in *Roe v. Wade*, 410 U.S. 113 (1975), the minor in this case does not select his own physician nor does he agree on a course of treatment following consultation with the physician. Rather the physician, acting on behalf of the state, evaluates and determines the necessity of confinement based upon the unverified conclusions of others and the policies of the institution (if such exist).[60] He is in effect the gatekeeper whose decision does not necessarily reflect the decisions of his "patient" and whose authority may not be questioned

[58] Shah, "Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior," 53 Mental Hygiene 21, 26 (1969).

[59] Dr. Messinger, A. 172.

[60] *See* pp. 36-42, *infra*.

by the "patient."[61] He has the awesome and arbitrary authority to confine without any checks or controls.

a. Admission procedures are arbitrary and utilize unverified information.

The admission procedure authorized by the statute fails to provide a proper basis for the decision to institutionalize in that it fails to ensure that all necessary information is obtained and to verify the validity of information relied upon by the admittting physician.

It is a truism that an admitting physician should have as much knowledge as possible concerning the child, his parents, and community. S. Chess, *An Introduction to Child Psychiatry* 47 (2nd ed. 1969). In order to obtain this information, two to three interviews over a period of time are recommended. J. Simmons, *Psychiatric Examination of Children* 6 (2nd ed. 1974); T. Schieff, *supra*, at 174.[62] Yet a diagnostic interview is often

[61] There is a distinction between a physician's diagnosis of a physical malady and its treatment, and the detection of a mental disorder. As Dr. Messinger stated: "One is not viewing . . . tissue . . . pathology that can be looked at . . . under a microscope—one is looking at complex and delicate relationships between people." A. 191. It is this difference which has caused the court to accord greater weight to a physician's recommendation of abortion than to a decision to institutionalize. *Compare Doe v. Bolton*, 410 U.S. 179, (1970) *and O'Connor v. Donaldson*, 442 U.S. 563, (1975).

[62] Several years may be required to learn the true facts. Dr. L'Abate, A. 801-02.

conducted in 30 minutes or less; and on the basis of this minimal contact the physician makes a decision which can result in the indefinite confinement of a child to a mental institution. The weakness of the present system is aptly illustrated by the admission of one of the named plaintiffs, J.L., who was admitted to Central State Hospital without any consultation with his primary out-patient therapist who felt strongly that institutionalization was not appropriate. Affidavit of Janet Scott, A. 61.

Further, the state alleges the existence of a statewide network of community mental health clinics; that the reports and referrals from these clinics are an integral part of the admission process.[63] The record indicates however, that this is an idealized conception. Dr. John Filley, Director, Office of Child Adolescent Mental Health Services stated that, "We haven't arrived at that point fully yet. We still get patients who are referred directly to the hospital . . . without recourse through the community."[64]

Testimony of the superintendents confirmed this fact.[65] Further, the community mental health centers are new programs which are just developing.[66] Few are

[63] Brief of Appellant at 33-34.

[64] Dr. Filley, A. 723. There is no statewide policy requiring referrals from community mental health clinics. *Id.*

[65] Dr. Miles, A. 250; Dr. Gates, A. 281; Dr. Bowling, A. 357; Dr. Kuglar, A. 556, 594-95; Dr. Mazur, A. 500.

[66] Dr. Filley, A. 768 "the child and adolescent services proportionately are . . . quite a bit less developed than general adult services . . . we ought to be providing 35% of services to children and adolescents. Actually, in many of the detention areas it was one-tenth or less as much service." A. 729.

able to employ full-time psychiatrists and many are overburdened.[67] These same observations apply to community mental health clinics in other states. Hobbs, N., *The Futures of Children* 216 (1975).

Although the physician often relies upon reports from others (notably the child's parents), there is no policy or procedure to verify this information. If there is a statement from a social worker or a clinic recommending admission, it is accepted as valid without further inquiry.[68] Where there are conflicting reports, it is still the sole decision of whoever the particular admitting physician happens to be, without any safeguards, checks, or necessity for the doctor to justify his decision.

A glaring example of such arbitrary action is demonstrated by one of the named plaintiffs. J.R. had been treated for over a year at a community mental health clinic in north Georiga. The psychiatric consultant at the clinic noted in his report of May 26, 1970 (one month prior to the child's admission) that J.R. was making progress and that "it would be of benefit to him . . . to stay in that foster home . . . since he has been in seven different foster homes and I feel that this must be very upsetting to him, and if he has to move, it would be even more upsetting." A. 153. Nevertheless, J.R.'s social worker, under pressure to find another foster home for J.R., sought institutionalization. There

[67] Dr. Mazur, A. 486, 490.

[68] "I don't know whether they get it [information] by hearsay from other persons or whether they observe it." Dr. Bowling, A. 367; Dr. Miles, A. 263; Dr. Jarrett, A. 472. "These reports are often incomplete." Dr. Gates, A. 284.

is no hospital record that the admitting physician at Central State Hospital had checked on the recommendations of the clinic concerning hospitalization; this appears even more suspect as J.R.'s degree of impairment was noted as mild on the admission forms. A. 130-34. As Dr. Filley acknowledged "DFCS [Department of Family and Children Services] takes the child to the hospital and says 'Now it's off our hands.' " A. 768.

Unfortunately, this is not a unique situation. As noted by the Joint Commission on Mental Health of Children, [and especially applicable to J.R.'s situation] "the State Hospital has been used at times by communities to relieve parents, courts, and other agencies of problem children. Referral is still too often a matter of expediency rather than a result of clinical judgment or a decision intended to provide the treatment that is most appropriate for the well-being of the individual child."[69]

If the minor's parents are available they are often relied upon to provide the primary information upon which the physician bases his diagnosis. Yet as the district court found, "the pathology of children is inextricably related to the pathology of family. . . . [M]ore often than not the parents as well as the child might need psychiatric help."[70] Rarely, if ever, will you have a purely emotionally disturbed child in a family

[69] Joint Comm'n on Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's*, p. 283.

[70] Opinion of the District Court, 412 F.Supp. at 133, citing Dr. Messinger, A. 163.

with no other problems . . . where there is a mentally ill child . . . it relates to the parents.[71]

Due to their own involvement or anxiety, the parents are more likely to focus on the behavioral characteristics of the child that they find unpalatable or which they consider sick and deviant.[72]

It follows that since parents are not neutral bystanders in this situation, the need for complete, accurate and verified information about the child prior to institutionalization is that much more compelling.

b. Commitment occurs in the absence of uniform admission policies and may be based on the subjective personal and professional views of the admitting physician.

There are no statewide policies which define the factors that are to be considered by a psychiatrist in making a determination as to the need for commitment. Dr. Skelton, A. 219-220. As a result, there is no uniformity as to admission policies within the state; each institution is free to develop its own policies or to

[71] Opinion of the District Court, 412 F.Supp. at 133, citing Dr. Jarrett, A. 473 and Dr. Bowling, A. 371.

[72] Dr. Messinger, A. 166. Parents may distort or forget valuable facts. S. Chess, *supra*, at 73. Although experts recommend that both parents be consulted and interviewed prior to admission, psychiatrists often see only one parent before making the decision to institutionalize. J. Simmons, *supra*, at 116-17, 122; S. Chess, *supra*, at 50-54.

leave the admission decision solely to the discretion of the individual physician.[73]

Consequently, the decision as to whether a juvenile will be committed depends not only on the particular personal and professional views of the admitting physician who happens to be on duty, but also on the particular regional hospital where initial evaluation and diagnosis is conducted. For example, a juvenile would be accepted at Georgia Regional Hospital at Atlanta only if his behavior was found to be out of control and "constituting a danger to themselves or others"[74] while the same child could be admitted to the Regional Hospital at Savannah if "he had been tried in other situations and not made it."[75] Clearly then, there can be no uniformity within the psychiatric profession as to when institutionalization is required and as to how this determination is reached.

Finally, complex psychiatric determinations aside, juveniles are sometimes admitted and confined simply because no one knows what else to do with them.[76] Thus, the record reflects that one child was admitted and confined at West Central Regional Hospital due to a "lack of community resources" while another juvenile remained confined because the community mental

[73] The admission decision may depend on a physician's subjective judgment of a family's home or socio-economic condition. R. Glascote, *et al., Children and Mental Health Centers* 973 (1972).

[74] Dr. Bowling, A. 356. Compare with Dr. Filley's opinion that dangerousness "is a fairly rare thing for children." A. 727.

[75] Dr. Craig, A. 524. *See* Central State Hospital Criteria for Admission, A. 346-49.

[76] Dr. Messinger, A. 170.

health center was unable to pick him up due to "work pressures."[77]

The foregoing evaluation of the state's admission process need not be construed as an "indictment of the psychiatric profession."[78] Even if written procedures, guidelines, and policies existed and applied uniformly throughout the state, and even if referrals from community mental health clinics were mandatory prior to admission, the present admission system would not be sufficient. The lack of even this minimal degree of uniformity and reliability points to an even greater likelihood of error in inappropriately institutionalizing a child under the present system.

Fundamental notions of due process demand that there be something more–a check on the absolute and arbitrary power of parents and the state to institutionalize a child when what is at stake is the freedom of the child, or conversely, the confinement of that child in a state mental institution possibly until his 18th birthday. The child's liberty interest demands nothing less.

D. This Court Need Not Determine The Full Range Of Due Process Safeguards Necessary To Protect A Juvenile Facing Confinement In A Mental Institution.

Not unsurprisingly, the lower court unanimously found that "neither the statutory scheme nor the

[77]A. 896, 895.

[78]Brief of Appellant at 20.

practices and policies of defendants provide for any procedural safeguards."[79] The three-judge panel did not attempt to determine the entire question of "what process is due" the juvenile.[80] *Morrissey v. Brewer*, 408 U.S. 471 (1972). It did determine that

> while the care that is implied in–the procedural regularity that is called for by the phrase "due process"–is flexible and such as the particular situation demands, *Morrissey v. Brewer*, it traditionally includes at least the right (after notice) to be heard before an impartial tribunal. *Powell v. Alabama*, 287 U.S. 45, 53 S.Ct. 55, 77 L.Ed.2d 158 (1932).[81]

Thus, the district court [and affirmance of its decision by this Court] requires only that the state provide notice and a hearing conducted by an impartial tribunal before it acts to indefinitely deprive a juvenile of his liberty by confining him in an institution. Further, the Court did not even deal with the parameters of the concept of "impartial tribunal"; thus, this court need not reach the issue of what specific due process

[79]Opinion of the District Court, 412 F.Supp. at 137.

[80]*See also, J.L. v. Parham*, 412 F.Supp. 141, 143 (M.D. Ga. 1976) (stay den.) "Unlike *Kremens [v. Bartley, supra]* the decision of this Court is only that some due process is required." A. 940-41.

[81]Opinion of the District Court, 412 F.Supp. at 137. As Daniel Webster's well-chosen words suggest, it "mean[s] a law which hears before it condemns, which proceeds on inquiry and renders judgment only after trial." Black's Law Dictionary, Revised 4th Ed. at 590; partially quoted in *Powell v. Alabama, supra.*

safeguards are required or the parameters of those safeguards.[82]

Contrary to appellants' assertions[83] the court in its order did not prohibit the state from providing mental health services to mentally ill children. It merely foreclosed the use of one specific method of commitment which did not pass constitutional muster. Noting that the full protections enunciated in this Court's decision in *In re Gault, supra,* were contained in the Georgia Juvenile Court Code,[84] the lower court allowed use of this statute, but did not prescribe the use of the juvenile court system as the exclusive constitutionally sufficient means of commitment of juveniles.[85] The district court further noted the existence of other mental health laws/court systems that could be utilized to place a child in one of the state's mental institutions. Thus, the Court did not attempt to legislate, but allowed the state's policy makers to explore other

[82]For a discussion of specific due process protections (counsel, pre- and post-commitment hearing, confrontation and cross-examination of witnesses, standard of proof, record, etc.) *see* amicus briefs. Appellees direct the Court's attention specifically to the amicus brief of the American Bar Association re: the right to counsel as a fundamental due process safeguard.

[83]Brief of Appellants, p. 52.

[84]Ga. Code Title 24A.

[85]412 F.Supp. at 136 and 139. Although the Juvenile Court Code provides that juvenile courts "shall have exclusive jurisdiction over juvenile matters and shall be the sole court of initiation action. . . ." 1971 Ga. Laws 709 (Ga. Code Ann. §24A-301) the lower court did *not* rule on the effect of this provision in this case. 412 F.Supp. at 131.

alternatives if they desired.[86] In fact, since the initial February, 1976 decision, the Juvenile Court Code has been amended to specifically provide for juvenile commitments to state mental institutions and a majority of juveniles are now committed pursuant to this statute.[87]

Since the district court did not reach the issue of specific safeguards, beyond notice and a right to be heard before an impartial tribunal, the discussion of (1) probable nature of additional safeguards and (2) the burden on the state are somewhat abbreviated. These issues will of course take on greater importance in situations where the lower court has ordered that additional protections be afforded. However, in the instant case, the district court has indicated that judicially created remedies (beyond the part of the order dealing with the 46 specific children which is treated in the last section of this brief) are not necessary. The court made it clear that the state and parents wishing to institutionalize children have several options under other state laws which were not under attack in this action, and that the Georgia General Assembly is of course, free to structure additional commitment laws as they deem necessary.

[86]The Georgia Legislature has established a Mental Disability Laws Study Committee to study, in part, the "voluntary" commitment of juveniles and to make a report, including suggested legislation to the 1978 Session of the General Assembly. I. General Acts and Resolutions, No. 16, p. 936 (1977).

[87]Ga. Code Ann. §24A-41; 1977 Ga. Laws 774; *See* Appendix A to Appellant's Brief.

E. The District Court's Limited Holding That Due Process Includes At Least The Right After Notice To Be Heard Before An Impartial Tribunal Warrants Affirmance.

1. Notice.

This Court has consistently found that notice is a fundamental aspect of due process.[88] To be meaningful it must be provided sufficiently in advance and with sufficient detail to allow a reasonable opportunity to prepare for the hearing. *In re Gault, supra,* at 33; *Wolff v. McDonnell,* 418 U.S. 539, 563 (1974). In mental commitment proceedings, where a person's liberty may be curtailed, notice is crucial. "Developments–Civil Commitment," *supra,* 1274-75; *Cf. Goldberg v. Kelly,* 397 U.S. 254 (1970).

That this case involves minors for whom rehabilitative treatment is being sought does not diminish the necessity of notice. Speculative fears of trauma to the child are not sufficient to overcome this basic requirement of due process. This position was raised by the State in *In re Gault, supra,* at 26, and found lacking. Indeed, for the minor who is not mentally ill, the trauma of suddenly being confined in a mental institution is far greater than receiving notice.

> The humanitarian desire to eliminate or curtail the use of such notice in such cases raises certain questions however. It may be, for example, that the experience of receiving notice would prove no

[88] *Baldwin v. Hale*, 1 Wall. 223, 233 (1864); *Grannis v. Ordean*, 234 U.S. 385 (1914). *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950).

> more traumatic for the patient than suddenly finding himself in a mental institition.[89]

2. Hearing Before An Impartial Tribunal

Although the length and severity of the deprivation are factors which determine the precise form of hearing required, due process includes a basic right to a hearing of some kind. *Goss v. Lopez,* 419 U.S. 565, 576 (1975). Due to the severity and indefinite nature of the confinement inflicted on the minor, a hearing by an impartial authority is part of the minimal process that is due.

A basic requirement of due process is that a hearing be held before a "fair tribunal." *McKeiver v. Pennsylvania,* 403 U.S. 528, (1970). Fairness involves not only "an absence of actual bias" but requires that "even the probability of unfairness" be removed. *In re Murchison,* 349 U.S. 133, 136 (1954).[90] "The due process right to a competent and impartial tribunal is quite separate

[89] American Bar Foundation, *The Mentally Disabled and the Law* (S. Brakel and R. Rock, eds.) 51 (rev. ed. 1971).

[90] "Circumstances and relationships must be considered. This Court has said, however, that 'every procedure which would offer a possible temptation to the average man as judge . . . not to hold the balance nice, clear, and true between the State and the accused denies the latter due process of law' " (citation omitted) 349 U.S. at 136. *Murchison* involved a state judge empowered under state law to sit as a "one man grand jury" and to compel witnesses to testify before him in secret about possible crimes; he charged two witnesses with contempt and then tried and convicted them himself.

from the right to any particular form of proceeding." *Peters v. Kiff*, 407 U.S. 493, 501 (1972).

In two recent decisions[91] this Court found due process satisfied by allowing the initial decision-maker to review his own decision. Both cases involved school disciplinarians and in each case the weight of the protected liberty loss, although not *de minimis*, was limited by the historical development of school discipline as part of the educational process.

In *Goss v. Lopez*, 419 U.S. 565, 582 (1975), this Court required that prior to an expulsion from school of ten days or less, a student must be told what he is accused of doing and what the basis of that accusation is.[92] It was recognized that "[B]rief disciplinary procedures are almost countless. . . ." and that they are part of the "teaching process." 419 U.S. at 583.[93] Although an impartial, independent review was not necessary for short suspensions, "[L]onger suspensions or expulsions for the remainder of the school term or permanently, may require more formal procedures."[94]

The liberty interest at issue in *Goss* involved a "property" right created by the state while the

[91]*Goss v. Lopez*, 419 U.S. 565 (1975) and *Ingraham v. Wright*, ____ U.S. ____, 97 S.Ct. 1401 (1977).

[92]It was recognized that there was a need for quick action following the misconduct, but that the teacher could "informally discuss the alleged misconduct with the student minutes after it occurred." 419 U.S. 582; 419 U.S. 594 (Powell, J., dissent.) (role of teacher).

[93]Compare with a child's average length of stay in Georgia state mental institutions–248.6 days.

[94]The suspension involved at a maximum 5% of the school year. 419 U.S. at 589.

infliction of corporal punishment in *Ingraham v. Wright*[, 97 S.Ct. 1401 (1977)] concerned the freedom from physical restraint.[95] Where this basic form of liberty is subject to restraint, the full range of procedural protections are usually required to satisfy due process.[96]

An historical analysis of paddling in schools, however, indicated that due to "the low incidence of abuse, the openness of our schools, and the common law safeguards that already exist, the risk of error . . . can only be regarded as minimal. *Ingraham v. Wright, supra*, at 418.

Clearly, these factors do not exist in the mental commitment of a juvenile.[97] The admitting physician does not possess the common law privilege to commit children. The authority to commit arises by statute and implicates the liberty interest of the child. In contrast to the school disciplinarian, the admitting physician operates within a *closed* institution and bases his decision on *un*observed conduct, *un*verified reports and *un*quantifiable standards.[98] As noted, the courts have

[95]97 S.Ct. at 1414, n.43; *Goss v. Lopez, supra*, at 576.

[96]See *Ingraham v. Wright, supra*, 97 S.Ct. 1414, n.44. Monaghan, "Of 'Liberty' and 'Property,'" 52 Cornell L. Rev. 405, 411 and 414 (1977).

[97]97 S.Ct. 1411, n.37, distinguishing the doubtful application of the Eighth Amendment's prohibition on cruel and unusual punishment to school discipline but leaving open its application to confinement in mental or juvenile institutions.

[98]Compare to 97 S.Ct. 1416 ("...paddlings are usually inflicted in response to conduct directly observed.").

uniformly questioned the validity of decisions made in this manner.[99]

Further, in cases not involving the special elements of *Goss* and *Ingraham* the necessity of an impartial tribunal has consistently been recognized. *See Goldberg v. Kelly, supra.* Even where a conditional liberty, such as parole revocation, was at stake, an impartial authority has been required to determine the validity of the proposed liberty loss. *Morrissey v. Brewer,* 408 U.S. 471, 481 (1972).

The admitting physician, like the parole officer in *Morrissey v. Brewer, supra,* at 486, is "directly involved in making recommendations and cannot always have complete objectivity in evaluating them."

One commentator has differentiated between the deprivation of liberty, even conditional liberty, and other "liberty losses." He includes civil commitment to a mental institution as one of the losses that require a "high level of procedural protection."[100] In light of the substantial risk of error involved in the physician's decision to commit a juvenile[101] and the absence of any of the historical safeguards noted above, the district court's finding that the statute in question did not contain the requisite due process which must be present before a juvenile is committed to a mental institution warrants affirmance by this Court.

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[99] *See generally O'Connor v. Donaldson*, 422 U.S. 563 (1975).

[100] Friendly, "Some Kind of Hearing," 123 U. Pa. L. Rev. 1267, 1296 (1975).

[101] See Section III.C.

F. The Burden On The State (Both Administrative And Fiscal) In Light Of Its Manifest Purpose To Act In The Best Interests Of Children Through Its *Parens Patriae* Power Is Minimal.

The Court was correct in leaving to the State's discretion the use of existing procedures (Ga. Code Chapter 24A within the Juvenile Court and the other provisions of Ga. Code Chapter 88-5 in the Court of the Ordinary) or developing other permissible procedures to commit children to its state institutions. As to new procedures, it is highly speculative as to the precise burdens which will be placed upon the State since the burden will vary greatly depending upon the nature and scope of these new procedures. However, what can be assessed at this point is the impact of using existing state laws.

Since 1969, 3,140 children have been admitted to the state's mental hospitals, and 35% of this number were committed through either the Juvenile Court or the Court of the Ordinary. Opinion of the District Court, 412 F. Supp. at 120. The fact that these alternate procedures have been used in recent years gives some indication that they have not proven excessively burdensome. The state estimates that approximately 264 children will be subjected to these proceedings next year. This compares with a total of 48,116 juvenile cases handled on a yearly basis in Georgia's juvenile courts. Opinion of the District Court, 412 F. Supp. at 145. If one considers that 35% of the juvenile commitments each year have already been handled in this matter, then the estimate of additional cases in the juvenile courts will be an even smaller

amount. Thus, it is difficult to consider how the state can realistically argue that the additional safeguards provided by existing law will constitute a significant burden on the state.

IV.

CONFRONTED WITH THE STATE'S ADMISSION THAT 46 INAPPROPRIATELY CONFINED CHILDREN WERE BEING HARMED BY CONTINUED INSTITUTIONALIZATION, THE DISTRICT COURT WAS CORRECT IN HOLDING THAT THE STATE'S INSTITUTIONAL CONFINEMENT OF THESE CHILDREN COULD NOT CONTINUE.

The district court was confronted in this case with the state's own admission that 46 children were confined in state mental hospitals, pursuant to the challenged voluntary admission statute, who in the opinion of professional hospital personnel did not need to be there. Opinion of the District Court, 412 F. Supp. at 124.

The State, when queried by the Court as to their intentions regarding the prospect of placement of these 46 children outside these institutions replied that no alternative facilities existed.[102] Further after consulta-

[102] The children remained confined despite a statutory obligation upon the superintendents of the eight regional mental hospitals to release any individual whose condition has sufficiently improved such that he no longer requires hospitalization. Ga. Code Ann. §88-503.2.

tion with the Governor and state legislators, the State refused to consider reallocating money at that time for alternative facilities for these children since the children were receiving "adequate treatment" in state mental health institutions. Opinion of the District Court, 412 F. Supp. at 138-39, citing Affidavit of Dr. Skelton.

However, contrary to this assertion of "adequate treatment," the State's own professionals as well as expert witnesses noted the harm that results to children who remain in institutions when there is no need for such confinement.[103] Further, in the case of the two named plaintiffs, hospital personnel had recommended placement outside the mental institution as early as *1973* (two years prior to the institution of this action) with no action taken by the State despite notations of the harmful effects of inappropriate institutionalization on their hospital records.[104]

[103] Dr. Filley, A. 766. "[It is therapeutically harmful to fail to place a child in an alternative setting to an institution when the child no longer requires institutional care] . . . because one wants to increase the child's adaptive capabilities. One wants the child to re-establish as soon as possible ties to the family, friends, schools, other community groups, so that the longer one postpones this, the harder it makes it for the child to re-establish those ties. Childhood is a time of relatively rapid intellectual, social and emotional development. A delay is of greater importance in a rapidly developing personality than it would be in a relatively fully developed adult, who is more static in his psychological functioning. Dr. Messinger, A. 183.

[104] A. 63-66. As early as 1973, hospital personnel recommended specialized foster care for J.L. (See p. 7 of transcript of testimony of Dr. Gutierrez). That recommendation was continually reaffirmed and documented in hospital records: "Continued hospitalization would not provide the emotional climate

(continued)

Finally, the district court was confronted with the 1973 Study Commission Report on Mental Health Services for Children which noted the inappropriate hospitalization of many children and the crying need for alternative facilities to place these children in. No action was taken by the State as a result of this report.[105]

(footnote continued from proceeding page)
necessary to meet J.L.'s needs. Recommendation: J.L. be considered for foster home placement with continued out-patient therapy." [Psychological Evaluation: 6/75]. A. 109. "Foster care would be most beneficial . . . he is obviously suffering from some degree of institutionalization and should experience success in a loving, concerned relationship as soon as possible." [Summary Progress Note: 6/75]. A. 98-99.

Recommendations for foster home placement for J.R. were made in early 1973 [Summary for Placement Resource: 6/73]. A. 145. "Central State Hospital has for some months been requesting long-term foster care or (an) adoptive home . . . *it is felt that (J.R.) will now only regress if he does not get a suitable home placement as soon as possible* . . . (he) has received maximum benefits from Central State's program."

This recommendation was subsequently reaffirmed and documented in the hospital records: "efforts to obtain a foster placement should be primary at this time lest J.R. becomes a permanently institutionalized child." [Psychological Evaluation: 8/73]. A. 156. "Foster care is recommended." [Restaffing: 11/74]. A. 158.

At the time the suit was brought in October, 1975, J.R.'s psychologist indicated that J.R. was "just a mildly retarded individual who needs structure and supervision but could function much better in a setting characterized by . . . a lot less structure . . . continued hospitalization would be harmful for J.R." (Dr. Hodges, A. 29).

[105] It is the observation of both hospital personnel and the Commission that more than half of the hospitalized children and youth would not need hospitalization if other forms of care were available in the community. Study Comm'n A. 908.

Here, the State had undertaken to act in *parens patriae*[106] with regard to these children by placing them in its mental health facilities for treatment.

This *parens patriae* power of the state has been specifically recognized by the Georgia courts[107] and, as to children, the common law *parens patriae* philosophy is now codified in the Georgia Juvenile Court Code, specifically, Ga. Code Ann. §24A-101:

> This code shall be liberally construed to the end that children whose well-being is threatened shall be assisted and protected and restored, if possible, as secure, law-abiding members of society; and that each child . . . shall receive . . . the care, guidance, and control that will conduce to his welfare.

1971 Ga. Laws, pp. 709, 710.

Because the exercise of this power necessarily involves a substantial restraint on the rd's freedom, due process requires that a particular scheme for protection of the mentally ill must rest upon a legislative determination that it is compatible with the

[106] State(s) are vested with the historic *parens patriae* power, including the duty to protect "persons under legal disabilities to act for themselves." *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972). See also *Mormon Church v. United States*, 136 U.S. 1, 56-58 (1890). The classic example of this role is when the State undertakes to act as "the general guardian of all infants, idiots, and lunatics." 3 W. Blackstone, *Commentaries* *47. See generally, "Developments–Civil Commitment," *supra*, at 1207-10 (nature and origins of the power).

[107] *Yeomans v. Williams*, 117 Ga. 800, 45 S.E. 73 (1903).

best interests of the affected class, and that its members are unable to act for themselves.[108]

Given the State's admission as to the harmful effects of inappropriate institutionalization then, it is difficult, if not impossible, to draw a rational relationship between the State's purpose in confining the 46 children in question in institutions [treatment for mental illness in order to restore the child to society–Ga. Code §24A-101] and the actual nature of that confinement [unnecessary institutional confinement that was harmful to the child]; and, without some form of treatment or benefit, the state's justification for acting as *parens patriae* becomes a nullity. *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973).

Thus, the court came face to face with the doctrine of substantive due process which is best exemplified in *Shelton v. Tucker*, 364 U.S. 479, 488 (1960):

> [E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.

In *Jackson v. Indiana*, 406 U.S. 715 (1972), this Court extended this principle to the now oft-quoted holding of that case: the nature and duration of

[108] *O'Connor v. Donaldson*, 422 U.S. 563, 583 (Burger, C. J., concurring). The purpose of exercising that power is to promote the interests of the individual. "Developments–Civil Commitment," *supra*, at 1222; American Bar Foundation, *The Mentally Disabled and the Law* at 34-40 (S. Brakel & R. Rock eds.) (rev. ed. 1971).

confinement must bear a reasonable relation to the purpose of confinement.

Clearly, as previously described, such a rational relationship did not exist in the instant case. And just as this Court further expanded *Jackson, supra*, in *McNeil v. Director, Patuxent Institution*, 407 U.S. 355, 358 (1971) [custodial confinement without treatment raises "substantial constitutional questions"] so is the *Shelton, Jackson, McNeil* line of cases applicable to the situation of the 46 children confronting the district court in this case.

In *McNeil* and *Jackson, supra*, this Court found that the necessary result of the unconstitutional confinement in those cases was release of the individuals involved. However, in this case, according to the district court's order, it is up to the state to decide how it is going to proceed with each of these children. The Court simply stated that there was one option that they didn't have–continued confinement of the 46 children *in institutions*.

Specifically, the court restricted its initial, preliminary relief[109] to steps which appeared essential to halt the harm and protect these children from further harm–*i.e.*, without making unreasonable demands on the state, but making its intent clear–by directing the state to "proceed as expeditiously as is *reasonably possible* (1) to provide necessary physical resources and personnel for whatever non-hospital facilities are deemed *by them* to be most appropriate for these children, and (2) to place these children in such non-

[109] The district court explicitly retained jurisdiction of the case, and anticipated clarifying its orders. 412 F.Supp. at 140.

hospital facilities as soon as *reasonably appropriate.*"[110] (emphasis added.)

The language of the court indicates that the state itself would be making determinations in fashioning the nature and scope of relief. The district court did not (nor does this Court) have to reach the issue of whether the retention of these 46 children by the state in non-institutional settings was constitutionally permissible.

Just as clearly and as reasonably, the Court's order that "the defendants shall spend such money of the State of Georgia as is reasonably necessary to provide such non-hospital facilities and personnel and to place these children in such non-hospital facilities"[111] is not barred by the Eleventh Amendment. This portion of the Court's order involves injunctive/prospective relief. As in *Ex parte Young*, 209 U.S. 123 (1908), state officials here were enjoined to form their future conduct to the requirement of the Fourteenth Amendment.

This Court has specifically recognized that injunctive relief may impose a heavy financial burden to the state:

> State officials, in order to shape their official conduct to the mandate of the Court's decrees, would more likely have to spend money from the state's treasury than if they had been left free to pursue their previous course of conduct. Such an ancillary effect on the state treasury is a permissible and often inevitable consequence of the principle announced in *Ex parte Young*.[112]

[110] Opinion of the District Court, 412 F.Supp. at 138.

[111] Opinion of the District Court, 412 F.Supp. at 139-40.

[112] *Edelman v. Jordan*, 415 U.S. 651, 668 (1974).

Thus the district court correctly concluded that the State could not continue to confine the 46 children in question in institutions relying on the reasoning in *Jackson*. Moreover, additional support for this result can be drawn from the Eighth Amendment prohibition against cruel and unusual punishment;[113] a "right to protection from harm;"[114] and a "right to treatment."[115]

[113] Without treatment, a mental hospital is no more than a prison. And a mentally ill person, confined without treatment, whether judged to have dangerous propensities or not, is being incarcerated as if his sickness were a crime. To so confine a person is unconstitutional. *Robinson v. California*, 370 U.S. 660, 666 (1962). And state authorities must, therefore, treat the patient or release him. *See also* n.37, *Ingraham v. Wright*, ____ U.S. ____, 97 S.Ct. 1401 (1977).

[114] In *New York Association of Retarded Citizens v. Rockefeller*, 357 F.Supp. 752, 764 (E.D. N.Y. 1973) (hereinafter *N.Y.A.R.C.*), the district court found release not an alternative for the mentally retarded inmates of the state institution in question because they were incapable of caring for themselves (functioning independently). However, despite this fact, the court found that, at the very least, the inmates possessed a basic "right to protection from harm" inflicted by conditions caused by or in the institution [similar to that of prisoners in criminal institutions].

[115] The constitutional right to treatment or release for involuntarily committed mental patients has received support over the last 17 years in numerous law review articles on the subject. *See e.g.*, Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); "Developments–Civil Commitment," *supra*; Note, "Rights of the Mentally Ill During Incarceration–the Developing Law," 25 U. Fla. L. Rev. 494 (1973); Comment, "*Wyatt v. Stickney* and the Right of Civilly Committed Mental Patients to Adequate Treatment," 86 Harv. L. Rev. 1282 (1973); Robitscher, "Right to Psychiatric Treatment: A Social-Legal Approach

(continued)

To paraphrase Justice Stewart [writing for the Court in *O'Connor v. Donaldson*, 422 U.S. 563, 574 (1975)

(footnote continued from preceding page)
to the Plight of the State Hospital Patient," 18 Vill. L. Rev. 11 (1972); Goodman, "Right to Treatment: The Responsibility of the Courts," 57 Georgetown L. J. 680 (1969); Katz, "The Right to Treatment–An Enchanting Legal Fiction," 36 U. Chi. L. Rev. 755 (1969); Note, "Civil Restraint, Mental Illness and the Right to Treatment," 77 Yale L. J. 87 (1967).

Further, the constitutional right to treatment or release for the mentally ill and the mentally retarded has been recognized by both federal and state courts. *See, e.g., Wyatt v. Stickney*, 325 F.Supp. 781 (M.D. Ala. 1971) and 344 F.Supp. 387, 390 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (class actions on behalf of the mentally ill and the mentally retarded); *Welsch v. Likins*, 373 F.Supp. 487 (D. Minn. 1974) (class action involving the mentally retarded); *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973); *Kesselbrenner v. Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973); *Renelli v. Dept. of Mental Hygiene*, 340 N.Y.S.2d 498, ____ N.E.2d ____ (1973).

There is also a widening body of precedent holding that there is a constitutional right to treatment for persons committed under "non-penal" statutes for the purpose of care and treatment: (a) juvenile delinquents, *Nelson v. Heyne*, 355 F.Supp. 451, 459 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352, 360 (7th Cir. 1974); *Inmates of Boys Training School v. Affleck*, 346 F.Supp. 1354, 1364 (D. R.I. 1972); (b) "persons in need of supervision," *Martarella v. Kelley*, 349 F.Supp. 575, 585, 598-600 (S.D. N.Y. 1972), *enforced*, 359 F.Supp. 478 (S.D. N.Y. 1973); *M v. M*, 336 N.Y.S.2d 304, 71 Misc.2d 396 (Fam. Ct. 1970); *In re I*, 316 N.Y.S.2d 356 (Fam. Ct. 1970); (c) sexual offenders and defective delinquents, *Stachulak v. Coughlin*, 364 F.Supp. 686 (N.D. Ill. 1973); *Davy v. Sullivan*, 354 F.Supp. 1320, 1328-29 (M.D. Md. 1973) (three judge court); *Gomes v. Gaughn*, 471 F.2d 794, 800 (1st Cir. 1973); *Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964), *cert. denied*, 407 U.S. 355

(continued)

and citing *Jackson v. Indiana*, 406 U.S. 715 (1972) and *McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972)]:

> [G]iven the [State's admissions as to inappropriate institutionalization] and resulting harm what was left as justification for keeping [these 46 children] in continued confinement? The fact that state law may have authorized confinement of the harmless mentally ill does not itself establish a constitutionally adequate purpose for the confinement. Nor [would it be] enough that [these children's] original confinement was founded on a constitutionally adequate basis, if in fact it was, because even if [their] involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed.

Clearly, the State cannot lawfully confine an individual thought to need treatment and justify that deprivation of liberty solely by providing some treat-

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(footnote continued from preceding page)
(1972); *In re Maddox*, 351 Mich. 358, 88 N.W.2d 470 (1958); *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 82 (1959); *Director of Patuxent Institution v. Daniels*, 243 Md. 16, 221 A.2d 397 (1966); *Silvers v. People*, 22 Mich. App. 1, 176 N.W.2d 702 (1970); and (d) persons incompetent to stand trial, *United States v. Walker*, 335 F.Supp. 705, 708 (N.D. Cal. 1971); *United States v. Pardue*, 354 F.Supp. 1377, 1382 (D. Conn. 1973); *Nason v. Superintendent of Bridgewater State Hospital*, 253 Mass. 604, 612-13, 233 N.E.2d 908, 913-14 (1968); *Maatallah v. Warden, Nevada State Prison*, 86 Nev. 430, 420 P.2d 122 (1970).

ment. Our concepts of due process would not tolerate such a "trade-off."[116]

Both the child and society itself have a stake in the child's inappropriate confinement, for as the court below noted: "every minute of unnecessary or inappropriate confinement and detention of a child in a mental hospital is a deprivation of liberty which affects him adversely and from the harmful effects of which he may never recover." District Court Stay Denial, 412 F. Supp. 141, 145. As in *Morrissey v. Brewer*, 408 U.S. 471 at 484 (1971), society has a stake in whatever may be the chance of restoring [a child] to normal and useful life within the law.

In conclusion, it is important to bear in mind that faced with a situation where the state admitted that harm was being inflicted upon those 46 children, that the district court fashioned a very narrow, reasonable, preliminary order as a first step towards removing that harm.

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[116] *O'Connor v. Donaldson*, 422 U.S. 563, 589 (1975). Burger, C. J. concurring. *See also* Dr. Hodges, A. 42:

> Q: The point I am getting to, Doctor, and that I am trying to make to the court is that we are not keeping them caged over at the Central State Hospital, each in his own little place, with no stimulants or anything else, are we? We are providing *some sort of services?*
>
> A: Yes.
>
> Q: There is professional help provided?
>
> A: We make every effort for that to be so. *In some cases that is not possible.* (Emphasis added.)

CONCLUSION

For the foregoing reasons, the Appellees respectfully urge this Court to affirm the decision of the lower court.

Respectfully submitted,

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September, 1977

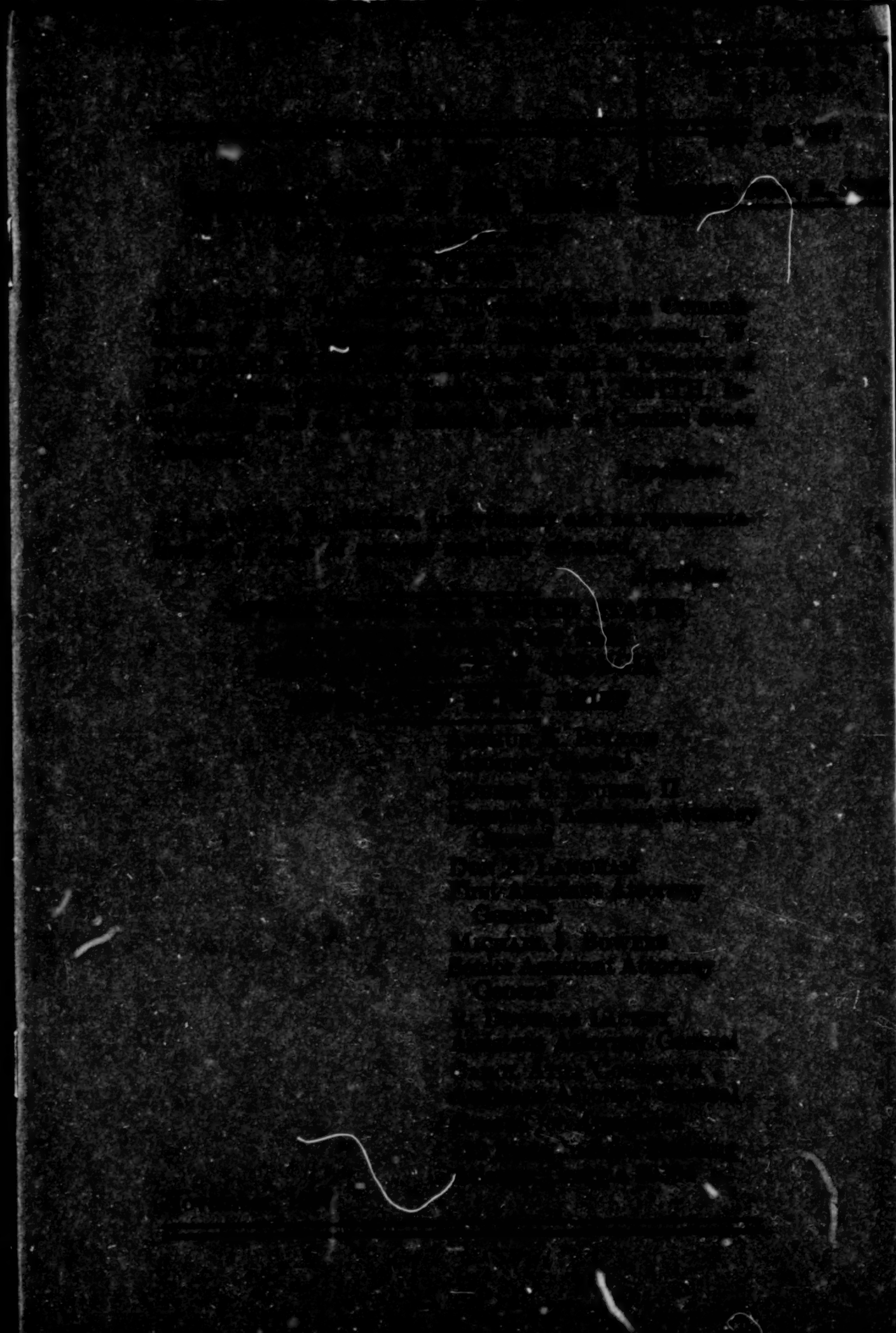
CERTIFICATE OF SERVICE

I, Gerald R. Tarutis, one of the attorneys for the Appellees herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served opposing counsel in this action with three copies of the foregoing Brief of Appellees by depositing three copies of the same in the United States mail, with first class postage prepaid, addressed as follows:

R. Douglas Lackey
Assistant Attorney General
132 State Judicial Building
Atlanta, Georgia 30334

This 22nd day of September, 1977.

GERALD R. TARUTIS
Counsel of Record for Appellees



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IN THE

Supreme Court of the United States

October Term, 1977

No. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and as representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

APPELLANTS' REPLY BRIEF

This brief is presented for the purpose of (1) identifying material issues which the Appellees have failed to address and (2) insuring that the framework within which this case is presented to the Court is as objective as it should be.

Specifically, with the exception of the United States, neither the Appellees nor *amici curiae* have directly ad-

dressed the critical issue of whether the "interest" sought to be protected in this litigation, the right of a child to refuse to accept medically-indicated treatment selected for the child by his parents, has a constitutional dimension.

Moreover, the analytical framework relied upon almost exclusively by the Appellees and *amici curiae* to support their position is predicated upon a parade of horribles. That is, their positions are supported in large part by generalizations which have been developed from historical sources or experiences in states other than Georgia, many of which bear no relation to the current provision of mental health care in Georgia, and most of which are directly contradicted by the evidence in the record.

This case is far too important to the children and parents who will be affected by this litigation to allow these matters to pass without comment.

A. THE APPELLEES AND *AMICI CURIAE* HAVE AVOIDED THE ISSUE OF WHETHER A CONSTITUTIONALLY PROTECTED INTEREST IS INVOLVED IN THIS LITIGATION.

The threshold issue in any case involving the alleged deprivation of a constitutional right to due process is whether the "interest" sought to be protected falls within the ambit of the Fourteenth Amendment to the Constitution of the United States.

This proposition was succinctly stated in *Smith v. Organization of Foster Families for Equality and Reform*, ——— U.S. ———, 97 S.Ct. 2094 (1977), where this Court, citing *Board of Regents v. Roth*, 408 U.S. 564 (1972), said:

> "The District Court decided that procedural due process guarantees apply in this case *by assessing and balancing* the particular interest involved . . . . [A]

> weighing process has long been a part of any determination of the form of hearing required in particular situations by procedural due process. *But, to determine whether due process requirements apply in the first place, we must look not to the 'weight' but to the nature of the interest at stake. . . . We must look to see if the interest is in the Fourteenth Amendment's protection of liberty and property.*" *Id.* at 570-571. [Emphasis added]

The "interest" involved in this litigation is the interest a child has in contesting a decision by his parents or guardian as to the desirability or necessity of medically-indicated treatment. We submit that medically-indicated decisions of parents and guardians, even though those decisions may ultimately result in the deprivation of the child's life or liberty, are routinely and properly left to the parents and the physicians whose advice they elicit and do not implicate any constitutional provisions which would require due process.

Only the United States acknowledges that this is an independent key issue which must be resolved before any "weighing" or "balancing" may be done. (Brief of United States, p. 23) However, even though recognizing that issue, the United States immediately joins Appellees and the other *amici curiae* who would resolve the threshold issue of whether a child may constitutionally refuse to accept treatment elected by his parents by looking to the risk of injury, the nature of the injury, and the deprivations that may flow therefrom.

This *ad hoc* determination of the existence of a constitutional right, however, is simply not consistent with this Court's prior decisions. Either the child has a constitutional right to refuse to accept medically-indicated treatment selected by his parents, in which case it will be proper

to "weigh" and "balance" the injuries which may flow from such a decision in order to determine "what process is due" to the child, or, in the alternative, the child has no such constitutional right, in which case this litigation must end.

The Appellants believe that utilizing the Appellees' and *amici curiae's* analysis has the effect of placing the cart before the horse. Under the analysis of the Appellees and *amici curiae*, whenever there is a possibility of an injury resulting from a parental decision, which, assuming State action, arguably could be brought within the protection of the Fourteenth Amendment to the Constitution, a constitutional right would spring into existence, a right which would allow the child to challenge that decision. The constitutional right thus created is not the result of any independent right that the child might have to contest his parents' decision, but arises solely from the potential for injury that flows from that decision. Thus, the Appellees and *amici curiae*, by following procedures normally utilized to determine "what process is due," have bootstrapped the children into a position where they could have a constitutional right which would not otherwise exist in the absence of potentially grievous injury to the child.

The factual situation in which this case arises tends to divert attention from the gap in the Appellees' reasoning. The following illustration should illuminate the weakness of the Appellees' and *amici curiae's* arguments.

Suppose a parent brings his child to a State-employed physician who works in a State-owned and operated hospital. The physician, after examining the child, determines that the child is exhibiting symptoms of a form of cancer, the treatment of which would involve the removal

of one of the child's legs. The parents are faced with the decision of whether to authorize the surgery.

Obviously, one consequence of the decision to authorize the surgery is that the child will lose his leg. This loss is a necessary result of the treatment for the illness from which, the doctor believes, the child suffers.

Clearly, if confinement and physical restraints constitute a "massive curtailment of liberty," the deprivation of one of the members of a child's body could constitute no less of a curtailment. Under the Appellees' and *amici curiae's* analysis, because the parental decision could result in a deprivation of the child's liberty, the original decision can only be made in a constitutionally permissible manner. That is, because the deprivation which flows from the decision results in an infringement on a constitutionally protected interest, the child is thereby given a constitutional right to challenge the original decision.

Of course, no one has argued that the child has a constitutional right to refuse this treatment, in spite of the severe consequences of the surgery. Indeed, the United States admits as much,[1] saying that it would be unprecedented to require due process in such a situation and that there is no case law which would support such a conclusion.

More to the point, it is clear that no one has argued that a child has a basic constitutional right to refuse medically-indicated treatment in all cases. Instead, the Appellees and *amici curiae* assert that this right exists in some cases, i.e., decisions involving the treatment of mental illness. Thus, they assert that a constitutional right exists not in all instances, but in only a few, depend-

[1] Brief of the United States, p. 23, note 25.

ing on the type of risk, and the injury that follows from taking the risk.

This would indeed be a unique and novel way to determine what rights flow from our Constitution and would require a complete reworking of this Court's opinions as to whether a constitutionally protected interest exists.

The better and more consistent course is to continue, as this Court has in the past, to examine the "interest" asserted to determine whether it is constitutionally protected, rather than "weighing" and "balancing" the potential results of an infringement upon that "interest" before determining if it is of constitutional dimension. Such an examination demonstrates, as Appellants assert in their main brief, that a child has no constitutional right to contest his parents' decision as to the necessity of medically-indicated treatment.

B. CHILDREN IN GEORGIA ADMITTED TO MENTAL HEALTH FACILITIES ARE NOT STIGMATIZED BY SUCH ADMISSION.

Appellees and *amici curiae* have asserted that children are invariably stigmatized by their admission to a State mental health facility, and that their interest in avoiding this stigmatization is sufficient ground to require the full panoply of due process rights.

The first answer to this assertion is to point out that the district court did not find in fact that any of the children in this case were actually stigmatized by hospitalization. Moreover, Appellees have pointed to no evidence in the record that the stigmatization of a mentally ill child who is institutionalized for a short period is greater than the stigmatization of a mentally ill child who receives non-institutional treatment. Finally, even if hospitalization

were important in and of itself, stigma can arise only if people are told that the child has been in the hospital. This explains the legal requirement that a person bringing a cause of action for deprivation of liberty due to stigmatization allege and prove that the stigmatizing information is published and disseminated by the defendant.

In *Bishop v. Wood*, 426 U.S. 341 (1976), a discharged police officer complained of stigmatization due to inaccurate charges of insubordination, "causing low morale" and "conduct unsuited to an officer." This Court assumed that the officer's discharge was a mistake and based on inaccurate information. However, this Court held that:

> "Since the . . . communication was not made public, it cannot fully form the basis for a claim that petitioner's interest in his 'good name, reputation, honesty or integrity' was thereby impaired." *Id.* at 348.

While Justice Brennan in his dissent argued that the information would inevitably be disclosed because the officer was "in a profession in which prospective employees are invariably investigated [and] petitioner's job prospects will be severely restricted by the governmental action in this case," the majority of this Court clearly required actual publication of the stigmatizing information before deprivation of a liberty interest could be established.

There is absolutely no evidence before this Court that the State of Georgia has or will ever publish any information which would indicate that any plaintiff had ever been admitted to a State mental health facility. In fact, the Georgia Code specifically makes the patient's clinical record a confidential document[2] and prohibits disclosure

[2] Georgia Code § 88-502.10 provides in pertinent part:

> "*Confidentiality.*—(a) A clinical record for each patient shall be maintained. The record shall include data pertaining to admis-

except in very limited circumstances. Even during the litigation in this case, the identity of the plaintiffs has been concealed to the greatest extent possible, with the major disclosure of the identity of the plaintiffs occurring only after the district court unsealed the depositions taken in the case and allowed the news media to review them, a disclosure which the district court later attempted to cure by ordering that all persons having knowledge of the identity of the plaintiffs not disclose such information.[3]

Thus, while the Appellees and *amici curiae* may generalize about the stigmatization flowing from the admission of a child to a State mental health facility, the record in this case clearly demonstrates that there is no publication of that information, and thus, references to patients' inability to obtain jobs, and similar assertions,[4] are entirely inappropriate and provide no basis for the existence of any constitutionally protected interest.

C. THE APPELLEES' AND *AMICI CURIAE'S* LEGAL THEORIES AND CONTENTIONS ARE PREDICATED UPON GENERALIZATIONS NOT APPLICABLE TO THE MATTER BEFORE THE COURT.

Appellees and *amici curiae* have tended to focus on broad generalizations rather than on the facts in the rec-

sion and such other information as may be required under regulations of the department. Unless waived by the patient or guardian and his attorney, the privileged and confidential status of all information given such status by section 38-418(5) shall not be lost by either authorized or unauthorized disclosure of such information to any person, organization or agency. The clinical record shall not be a public record and no part of it shall be released [except in specific enumerated cases]." [Bracketed matter added].

[3] Order of District Court entered December 19, 1975.

[4] Appellees' Brief at 32-33.

ord. This erroneous approach to this case is of great concern to Appellants, who designed their admissions procedures, programs of treatment and the other aspects of their mental health care efforts with a view to what presently exists in Georgia, not with a view to what formerly existed in Georgia or what may exist elsewhere.

Appellants believe that it is necessary to correct the record on the parade of horribles relied upon by Appellees and various of the *amici curiae*.

1. The record refutes Appellees' generalization that State mental health facilities in Georgia are overcrowded, under-financed or under-staffed.

The briefs of the Appellees and *amici curiae* assert again and again that State mental health patients are placed in deplorable, decrepit facilities which are overcrowded, under-financed and under-staffed. One brief actually declares:

> "The snake-pit conditions of most of our mental hospitals are so wide-spread as to have reached almost universal recognition." [5]

The Appellees attempt to capitalize on this type of generalization by noting that at one time the State mental health facility in Milledgeville, Georgia, was the largest mental hospital in the world, with 12,000 patients.[6] Appellees then assert, in the same paragraph, that the present population of that same facility is 7,523 patients, and cite as authority the district court's opinion.[7]

However, the Appellees, in their zeal to suggest that terrible conditions exist in the State mental health facilities, misread both the district court's order and the evi-

[5] Brief of the Child Welfare League, at p. 25.

[6] Appellees' Brief at 24.

[7] *Id.*

dence. The district court stated, correctly, that there were 7,523 patients, but this included both the mentally ill and the mentally retarded, *throughout the entire State-wide system, including all eight regional hospitals as well as several institutions for the mentally retarded.* The district court did not find, the evidence does not demonstrate, and it is not true that there were over 7,000 patients in any one facility.

Moreover, the evidence presented to the district court did not demonstrate any current over-crowding or decrepit conditions in these State facilities. Dr. Messinger, the Appellees' expert witness, testified that while he was not happy about the physical facilities of the adolescent unit located at Central State Hospital, that he was "favorably impressed by the children's unit." Even with respect to the adolescent unit, Dr. Messinger did not testify that it was decrepit, over-crowded or under-staffed. He did say, in regard to the adolescent ward, that:

> "It was dismal, clean; the personnel seemed concerned and knowledgeable about, you know, their roles in the ward, but it truly was dreary." A-187.

Finally, as the record clearly indicates, the three members of the district court visited two of the State mental health facilities involved in this case. It is apparent from a reading of the opinion of the district court that it was not engaged in any kind of white-wash; had the court found bad conditions they would have been described in the opinion. However, the district court did not say that the judges found the facilities to be over-crowded or understaffed. Nor did the district court find the facilities to be "deplorable" or "decrepit," or a "snake-pit," or anything remotely like the assertions of Appellees and *amici curiae.*

The court did, of course, include findings which Appellees fail to mention about the financing of the menta

health program in the State of Georgia. The court specifically found that during fiscal year 1976, a total of $149,971,859.00 was appropriated directly for the provision of mental health care in the State of Georgia. As the court's figures demonstrated, almost one-third of the entire budget appropriated to the Department of Human Resources in the State of Georgia, the agency generally responsible for the provision of welfare services to the State's citizens, was earmarked specifically for mental health services. Moreover, using the district court's figures again, it is evident that the amount appropriated for the direct provision of mental health care in Georgia was almost 7% of the entire State budget during that fiscal year. While adequacy of financing is obviously a subjective concept, it is apparent that a substantial amount of the annual appropriations of the State of Georgia are spent for the provision of mental health care.

2. The absence of parents ready, willing and able to again accept their child after admission to a State mental health facility is not "a normal situation."

In an attempt to demonstrate an alleged conflict between parents and their children, the Appellees and several *amici curiae* relied upon the district court's generalization that:

> "The absence of parents ready, willing and able to again accept their child, is unfortunately a normal situation." 412 F. Supp. at 135.

The Appellees cite this generalization as a fact in their Statement of the Case.[8] Moreover, the Appellees attempt to support the district court's generalization by quoting the testimony of Dr. Everett Kuglar, the Superintendent of the Georgia Regional Hospital in Augusta, as follows:

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[8] Appellees' Brief at p. 4.

"The big problem is very often not getting the child well enough to go home, but getting the parents essentially, you know, [to] even take this child."[9]

The Appellees suggest, based on these "facts" that parents cannot be trusted to make correct decisions for their children. A closer look, however, shows that the situation is not as Appellees have portrayed it.

The district court's comment that parents are unwilling to accept their children after admission to a mental health facility was predicated specifically upon the testimony of Dr. James B. Craig, the Superintendent of the Georgia Regional Hospital at Savannah, who, according to the district court's opinion, testified that:

"Yes, you always have a few of these [parents who are reluctant to take their children out of a hospital after the staff recommends the discharge] because with the kinds of, say, cases you get admitted to a hospital, meaning that many times it's because of their disinterest and inability to get along when the child gets sick." 412 F. Supp. at 135. [Bracketed material in original].

Dr. Craig stated in his deposition, as did several other superintendents, that he was merely guessing at the number of children whose parents might be reluctant to take their child back [A-530], but in any event, the word Dr. Craig used was "few," not "normal."

The quote taken from Dr. Kuglar's testimony, considered in context, does not support the principle for which it was advanced; the full paragraph from which the quote was taken appears as follows:

"No. I don't see how it [the problem of parents running away] would be present during the admission process. Very often what has occurred here, is

[9] Appellees' Brief at p. 30, note 32.

that the child is brought to the hospital sometimes, by the judicial process, through the court system, and the parents feel like they didn't have any part in the admitting of this child to the hospital and aren't going to have anything to do with it. There often—is an amount of hostility and antagonism between them and the child which has reached the point where they don't want to accept this child, and *the big problem is very often not getting the child well enough to go home, but getting these parents to essentially, you know, to take this child.* And on one or two occasions we had to go back into the Court or through D.F.C.S. [County Department of Family and Children Services] to get a disposition made. There haven't been a lot of these, but they do occur. I don't see any sense, you know, I'm not trying to hide that sort of thing does occur." A-578-579. [Appellees' quotation italicized]. [Bracketed matter added].

Taken in context, the statement by Dr. Kuglar clearly indicates that the problem with parents refusing or being reluctant to take their children back arises primarily when the child has been brought into the hospital through the court system. This is especially important because Appellees ask for more court participation in the admission process. Thus, it is likely that ordering more court hearings would exacerbate whatever problem now exists.

More in point is Dr. Kuglar's testimony when he was specifically questioned about cases where parents were reluctant to take children back home after the hospital had recommended discharge. In response to the question about the frequency of this occurring, Dr. Kuglar responded as follows:

"Upon rare occasions we do. I'm sure we could recall a—two or three or four episodes during the last three or four years where this was a problem, but it's rarely a problem." A-561.

Using the worst combination referred to by Dr. Kuglar, four episodes of parental reluctance during the previous three year period, would result in a parental abdication in only four instances out of 299 actual discharges.[10]

Thus, while Appellees assert that parents normally refuse to take their children back after they have been admitted to a State mental health facility, the specific facts in the record contradict this generalization.

3. The average length of hospitalization is far shorter than the period alleged by the Appellees.

The Appellees interject into their argument the alleged fact that:

> "The average length of confinement for the class as a whole was 248.6 days, and at Milledgeville it was 456 days." [11]

The class that has been certified includes all those children who were in the hospital at the time the suit began, as well as "all persons younger than 18 years of age . . . hereinafter received by any defendant for observation and diagnosis. . . ." Opinion of the District Court,

[10] A-856.

[11] Appellees' brief at p. 32. The Appellants have been unable to determine how this figure was derived, since it is at variance with the figure stated by the district court in its opinion. The distinction between the two, to the extent that the Appellees' figure is based on the district court's opinion, is probably irrelevant since the district court's figures are also obviously in error. For example, the district court's opinion notes that the maximum time of confinement for any member of the plaintiffs' class at Central State Hospital on October 31, 1975 was 2,035 days. J.L., who had been there the longest, had been admitted on May 18, 1970, an interval of 1,992 days, not 2,035, even if leave from the hospital is ignored. Similarly, the court's opinion indicated that the minimum time of confinement for any member of the class then in Central State Hospital was 22 days. The record clearly shows that on October 31, 1975, the minimum time of confinement for any class member was 14 days, not 22. Similar discrepancies exist with the rest of the figures.

412 F. Supp. at 117. Thus, the relevant statistic is the period of hospitalization that a child in the class could anticipate. This being the case, it is grossly misleading to consider only the average period of hospitalization of those children who were in the hospital at the beginning of the litigation. A more descriptive figure is obtained by considering the length of hospitalization of all those children who have been admitted under the challenged Code section. Even this figure is somewhat overstated, since it is skewed by the handful of children who have been in the hospital for extended periods.

An analysis of the data in the record, including the duration of hospitalization for the previously discharged children, demonstrates that the median stay for all children hospitalized under the challenged Code section is less than 56 days. The mean or average stay for all of these children, including the named plaintiffs as well as the three or four other children who had been in the hospital for long periods, is only slightly over 142 days.[12]

Moreover, the same statistics demonstrate that of the 2,003 children voluntarily admitted to the hospital under the challenged Code section and subsequently discharged, 197 were discharged during the first 7 days of their hospitalization, an additional 178 were discharged during the next 7 days, another 317 were discharged during the next 15 days and over 1,300 were discharged in the first three months.

These figures, all of which are derived from the record, are certainly more descriptive than Appellees' characterization of "average lengths of confinement." Appellees' case is built on the adverse consequences of prolonged

[12] These figures were developed from the data found on pages A-824-887, using standard statistical analysis techniques and assumptions.

institutionalization. It is therefore important to note that most children are not institutionalized for extended periods, that most of the children in the hospital need to be there, and that Appellees overstate the average stay by nearly 75%.

4. The evidence in the record does not support the view that State psychiatrists tend to institutionalize persons unnecessarily.

Appellees and various of the *amici curiae* ascribe to the view that State psychiatrists tend to institutionalize persons unnecessarily. For example:

> "The tendency of mental health professionals to prescribe institutionalization for persons not in need of confinement has been widely noted. Various empirical studies have verified it." [Footnotes omitted].[13]

> "Empirical studies have demonstrated that psychiatrists and physicians employed by State mental institutions, recommend institutionalization of persons not in need of confinement." [Footnote omitted].[14]

With these generalizations Appellees and *amici curiae* attempt to establish the existence of a substantial risk of erroneous institutionalization of a child who either is not mentally ill or is not suitable for treatment in a mental health facility. However, these generalizations are substantiated neither by the record, nor, for the most part, by the studies cited by the Appellees and *amici curiae*.

First, the record clearly demonstrates that the State of Georgia has an extensive community mental health program, as well as the in-patient program which is the subject of this litigation. The district court itself noted that in fiscal year 1974, 5,596 children were treated as out-

[13] Brief of American Orthopsychiatric Association, et al., at pp. 33-34.
[14] Appellees' Brief at p. 44.

patients and only 515 were treated as voluntary in-patients. While this, of course, does not establish the appropriateness of the hospitalization of any of the 515 children, it does indicate that the State has non-hospital resources, and makes extensive use of them.

No comprehensive statistics were developed at the trial of this case to determine the number of prospective hospital patients who, throughout the system, are turned away and denied admission to the hospital, although there is an indication in the record that this happens frequently. For instance, Exhibit 9 to the deposition of Dr. Donald G. Miles, Superintendent of the Georgia Mental Health Institute in Atlanta, demonstrates that between July 1, 1967 and June 30, 1971, (the period during which the hospital was doing its own initial screening rather than having patients screened through community health centers), 635 applications for admission were received. Of these, 170 were cancelled and nearly 50% of the remaining children for whom admission was sought were rejected.

Of course, the question of whether a particular child should be admitted to a hospital is a question of medical judgment. And as with any judgment, whether it involves mental illness or physical illness, there is a possibility of an error. However, Appellants would emphasize that *the district court did not find that a single child had ever been admitted to a State mental health facility when hospitalization was not warranted*, and the generalizations relied upon by the Appellees and *amici curiae* do not belie this fact.[15] It also bears repeating that it is a serious error to

[15] The American Orthopsychiatric Association, et al., in their brief, evidently recognize the need to shore up this aspect of their presentation. On page 44 of that brief, *amici curiae* suggest that Appellants conceded that J.L. was hospitalized for reasons other than his own best interests as follows:

deny institutional care to a child who needs it. Appellees' implication that decreasing hospitalizations would be advantageous *per se* therefore cannot be accepted.

Turning to the "empirical studies" referred to above, most of the studies relied upon by the Appellees and *amici curiae* deal with the ability of psychiatrists to predict the future conduct and behavior of mentally ill persons. *See e.g.*, Ennis and Litwack, *Psychiatry and the Presumption of Expertise; Flipping Coins in the Courtroom*, 62 Calif. L.R. 693 (1974); Rappeport, Lasson and Gruenwald, *Evaluation and Followup of State Hospital Patients Who Had Sanity Hearings*, 118 Am. J. Psychiatry 178 (1962).

The ability of a psychiatrist to predict future behavior, such as dangerousness, is not at issue in this litigation and is not presently defended by Appellants. The challenged statute requires no such prediction, but simply a determination that a child is mentally ill and is suitable for treatment in a hospital. Thus, studies which suggest

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"The case of J.L. is illustrative. It was stipulated that this child was hospitalized because his mother was concerned that he was adversely affecting her relationship with her second husband and her child."

There is no such stipulation anywhere in the record. The stipulation to which *amici curiae* apparently refer is as follows:

"The admitting physician determined that hospitalization was appropriate because J.L. could 'not function outside the hospital and admission might be helpful'." A-68.

This stipulation makes it plain that J.L. was accepted by the hospital because he needed hospital care, and not for any other reason. *Amici curiae's* implication that J.L.'s mother coldly rejected him is refuted by the very Exhibit relied upon by *amici curiae*. In that Exhibit, J.L.'s mother was described as follows:

"She [J.L.'s mother] really cared for Joey and it was a painful, traumatic decision to give him up. It is to her credit that she dealt with the feelings of helplessness and hopelessness Joey created for her in the hope he could be put in a successful foster home." A-96.

that psychiatrists cannot predict whether mentally ill persons will commit acts of violence in the future have no relevancy at all to this case.

One study cited in the briefs of *amici curiae* does purport to deal with the ability of a psychiatrist to diagnose mental illness. That is the study conducted by Dr. David Rosenhan.[16]

Dr. Rosenhan arranged for eight persons to apply, voluntarily, to 12 different mental hospitals, with each person reporting falsely that he was hearing voices saying "empty," "hollow," and "thud." Each person was admitted. Each was subsequently discharged as being "in remission," even though none had disclosed to the hospital staff that he was faking. Each person simply reported, after his admission, that he had stopped hearing the voices. From this rather simplistic study, *amici curiae* and a great number of other persons have concluded that psychiatrists cannot correctly diagnose the presence or absence of mental illness.

Dr. Rosenhan's study has been subjected to rather severe criticism,[17] and rightly so. The most succinct comment is that the study simply proves that it is possible to trick a psychiatrist. The study has little to say about a psychiatrist's relative ability to accurately diagnose illness, for physicians attempting to diagnose physical

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[16] Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara L.R. 379 (1973). [Cited in the Brief *amici curiae* of American Orthopsychiatric Association, et al., pp. 34, 35 and the Brief *amicus curiae* of The American Bar Association, p. 22.]

[17] Dimond, *Popular Opinion is Not Empirical Data*, 2 Clin. Soc. Work J. 264-270 (1974); Kety, *From Rationalization to Reason*, 131 Am. J. Psychiatry 957 (1974); Pattison, *Social Criticism and Scientific Responsibility*, 26 J. Am. Sci. Affil. 110 (1974); Spitzer, *More on Pseudoscience and the Case for Psychiatric Diagnoses*, 33 Arch. Gen. Psychiatry 459 (1976).

illnesses must also depend upon the symptoms expressed by the patient. One commentator demonstrated the invalidity of Dr. Rosenhan's study as follows:

> "If I were to drink a quart of blood and, concealing what I had done, come to the emergency room of any hospital vomiting blood, the behavior of the staff would be quite predictable. If they labeled me and treated me as having a bleeding peptic ulcer, I doubt that I could argue convincingly that medical science does not know how to diagnose that condition." [18]

Studies frequently assist a court in arriving at its decision, and generalizations have their place in a case as important as this. However, as the foregoing review demonstrates, studies and generalizations are no substitute for the facts in the record, especially where, as here, the studies are characterized by dubious methodology and the generalizations are shown by the record to be inapplicable to the case before the Court.

D. THE QUESTION OF WHETHER THE STATE, IF IT IS TO PROVIDE SERVICES TO ITS MENTALLY ILL CITIZENS, MUST PROVIDE NEEDED MENTAL HEALTH SERVICES IN THE MOST APPROPRIATE TREATMENT SETTING, IS RIPE FOR DECISION.

Several of the *amici curiae*, including the American Orthopsychiatric Association, et al. and the United States, ask this Court not to decide the third question presented in this case. That question can be stated as follows:

> "Whether, assuming that more than one treatment setting would benefit a mentally ill person under 18 years of age, the Fourteenth Amendment to the Constitution of the United States mandates that the State must, if it is to provide services at all, provide needed mental health services in the most appropriate treatment setting commensurate with the minor's condition?"

[18] Kety, *From Rationalization to Reason*, 131 Am. J. Psychiatry 957 (1974) at p. 959.

Amici curiae American Orthopsychiatric Association, et al. argues that the matter is not ripe for one of two reasons, both of which relate to children presently in the hospital:

(1) Assuming the district court was correct, that the children were being detained unconstitutionally, there is no need to address the second issue as to their proper placement; or (2) assuming the district court was incorrect, and that there has been no unconstitutional detention, the resolution of the question of the proper placement of the children needs further evidentiary development.[19]

The brief of the United States asserts that the matter is not ripe for adjudication because it is not clear whether the district court's order that the minor be placed in "the least drastic environment necessary for treatment," was based upon the court's finding that hospitalization constitutes a violation of substantive due process, or whether the order was simply an exercise of the court's equitable power to require Appellants to remedy the effects of the initial denial of procedural due process or of unjustified continued confinement of the identified children.[20]

Amici curiae ignore the specific language found in the district court's opinion denying the stay to the Appellants in this case. There the district court said:

> "Implicit in this court's February 26, 1976 order, is

[19] Brief of American Orthopsychiatric Association, et al., pp. 10-11, note 3.
[20] Brief of the United States, pp. 33-36.

> the court's considered opinion that *every minute of unnecessary or inappropriate confinement and detention of a child in a mental hospital is a deprivation of liberty* which affects him adversely and from the harmful effects of which he may never recover. That considered judgment has not changed." A-944. [Emphasis added].

It is absolutely clear that the district court's opinion with respect to hospitalized children for whom other optimally appropriate settings could be identified was founded upon the district court's conclusion that continued hospitalization was depriving those children of their liberty in violation of the Fourteenth Amendment. That portion of the district court's order was therefore not merely remedial, but was predicated upon a separate and independent constitutional right to liberty from "unnecessary or inappropriate confinement." As such, there is no basis for concluding that this issue is not now ripe for adjudication.

CONCLUSION

For the reasons stated in the Brief of Appellants and herein, we urge the Court to reverse the judgment of the district court.

Respectfully submitted,

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IN THE SUPREME COURT

OF THE

UNITED STATES

OCTOBER TERM, 1977

NO. 75-1690

T. M. "JIM" PARHAM, et al.,

Appellants,

-vs-

J. L. and J. R., et al.,

Appellees.

Appeal From The Judgment Of The United States District Court For The Middle District of Georgia

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BRIEF OF THE CHILD WELFARE LEAGUE OF AMERICA AS AMICUS CURIAE IN SUPPORT OF APPELLEES

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IN THE SUPREME COURT

OF THE

UNITED STATES

OCTOBER TERM, 1977

NO. 75-1690

T. M. "JIM" PARHAM, et al.,

Appellants,

-vs-

J. L. and J.R., et al.,

Appellees.

Appeal From The Judgment Of The
United States District Court For The
Middle District of Georgia

BRIEF OF THE CHILD WELFARE LEAGUE OF AMERICA AS AMICUS CURIAE IN SUPPORT OF APPELLEES

INTEREST OF AMICUS CURIAE[1/]

For over fifty years, the Child Welfare League of America has been an

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1/ A joint letter from counsel for both appellants and appellees, granting permission for Amicus to file this brief, has been filed with the Clerk of the Court.

advocate for children, devoting its efforts to the improvement of care and services for deprived, neglected and dependent children. The League is a non-sectarian federation of almost 400 child welfare agencies in the United States and Canada. It provides leadership and services to the child welfare field, and serves as a national clearinghouse and forum for exchange of knowledge and experience. It acts as a coordinator, a catalyst, and an advocate.

Almost all League affiliates provide direct services for children, services that reinforce the ability of parents to meet the child's needs, services that supplement the care which the child receives from parents, and services that substitute for parental care when necessary. Among the many services provided by affiliates are services for children in their own homes, protective services, shelter care, day care, homemaker services, foster family care, group home care, institutional care, residential treatment for emotionally disturbed children, adoption services, day treatment,

maternity homes and services for unmarried parents. In addition, the League itself conducts research, provides consultation to agencies and communities, provides information for public education, organizes annual regional conferences, and publishes a monthly journal, Child Welfare, a quarterly CWLA Newsletter, and numerous pamphlets and leaflets.

Amicus thus combines extensive experience in children's mental health treatment programs with a longstanding concern for promoting opportunities which will contribute to the health and well-being of children. Amicus has reviewed the arguments presented below by the parties and Amici, as well as by appellants herein; Amicus believes that it will bring to this case considerations, information, and a perspective which will be of assistance to this Court in passing upon the significant issues raised by this appeal.

QUESTIONS PRESENTED

1. Whether the Due Process Clause of the Fourteenth Amendment to the United States Constitution requires

that children be afforded judicial hearings before they may be committed to state mental hospitals by their parents or guardians?

2. Since the Georgia legislature has determined that children fourteen years of age or older possess sufficient maturity and understanding to be entrusted with a number of significant rights and responsibilities, are these children entitled to the same pre-commitment hearings as adults under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution?

SUMMARY OF ARGUMENT

Incarceration in a state mental hospital constitutes a severe deprivation of a minor's liberty, as well as a number of other constitutionally protected rights, including the minor's right to privacy and freedom of association. Presumptively, deprivation of these rights must be safeguarded by some type of due process hearing. Hearings are not required only in those limited circumstances where: (a) there is no significant risk of erroneous

deprivation of the protected interest; (b) there are adequate, substitute procedural safeguards; or (c) the fiscal or administrative burdens caused by the due process requirements would be unduly onerous.

None of these limited exceptions apply in this case. Since psychiatrists are unable to agree even in their most gross psychiatric diagnoses, judicial hearings are required to safeguard the minor's liberty. These hearings are also necessary because Georgia law does not even require the hospital to find that a minor suffers from a mental illness before accepting him for treatment; and because of the well-documented bias of psychiatrists in favor of committing healthy persons to mental hospitals, rather than risking the error of allowing mentally disordered persons to go free. Given the time and resource constraints which frequently make comprehensive psychiatric evaluations impracticable, psychiatrists tend to support the parent who has already concluded that his child requires hospitalization.

Unfortunately, the parent s judgment

is frequently suspect. In placing their children in mental hospitals, many parents are responding to familial difficulties to which the parents themselves may be contributing and in which they are, in any event, participants. Under such circumstances even the best-intentioned parent may find it difficult to make a rational decision about how to cope with intra-family strife. The potential, and frequently actual, conflict of interest between a child and his parents in such times of stress has caused a number of courts to hold that the distinct interests of the child in cases such as this can only be safeguarded in a judicial hearing at which the child is represented by independent counsel.

Unlike many jurisdictions, Georgia does not require that the minors be screened and evaluated by community mental health centers before they may be placed in state mental hospitals. Hence, no argument can be maintained that a substitute procedure sufficient to satisfy due process exists. Although the fiscal and administrative burdens caused by pre-commitment hearings will

not be inconsiderable, they are far less onerous than burdens imposed by this Court previously in implementing the due process guarantee.

The record in this case demonstrates what is confirmed by numerous studies: many children placed in state mental hospitals could just as easily have been committed to state training schools because they have committed delinquent acts or status offenses which fall within the jurisdiction of the juvenile court. Because of the considerable overlap between the populations of state training schools and mental hospitals, and the arbitrariness of the process by which it is determined that minors will be channelled into one system rather than the other, In re Gault cannot be distinguished on the basis that it relates solely to quasi-criminal conduct. Like Gerald Gault, appellees are being subjected to massive deprivations of numerous constitutional rights upon the pretense of providing them with meaningful treatment. Unfortunately, many minors confined in mental institutions are at best exposed to protective custody; at worst they

live under brutalizing and inhumane conditions. Hence, absent some constitutionally adequate justification for treating appellees here differently from children in juvenile courts, appellees must receive the same due process protections mandated by Gault.

Legislative distinctions between children and adults generally rest upon the assumption that minors lack the maturity and judgment necessary for reaching reasoned decisions. Georgia, however, has determined, in a variety of contexts, that children fourteen years of age or older are sufficiently mature to be entrusted with extensive rights and responsibilities. In Georgia thirteen is the age of criminal responsibility and at age fourteen minors may admit themselves to state mental hospitals -- although this power is subject to the parent's later right of disaffirmance. Having determined that age fourteen is the dividing line between mature and immature minors, Georgia's denial of hearings to minors fourteen years of age and older serves no significant, or even rational, state interest. Hence, even if, arguendo,

this Court rejects Amicus' due process argument, appellants' statutory scheme must be invalidated under the Equal Protection Clause as it applies to minors over the age of thirteen.

ARGUMENT

I. INCARCERATION IN A STATE MENTAL INSTITUTION CONSTITUTES A SEVERE DEPRIVATION OF A MINOR'S LIBERTY AND IMPLICATES A NUMBER OF THE MINOR'S OTHER CONSTITUTIONALLY PROTECTED RIGHTS.

A. Children are Protected in Their Liberty by the Due Process Clause of the Fourteenth Amendment.

It is by now well-established that children fall within the ambit of the Due Process Clause of the Fourteenth Amendment. Ingraham v. Wright, 51 L.Ed. 2d 711, 731 (1977); Goss v. Lopez, 419 U.S. 565 (1975); In re Gault, 387 U.S. 1 (1967); Kent v. United States, 383 U.S. 541 (1966). As this Court observed in its landmark decision of In re Gault, supra, the word "person" in the Due Process Clause is not limited to adults, for "neither the Fourteenth Amendment nor the Bill or Rights is for adults alone." 387 U.S. at 13.

The due process protections of the Fourteenth Amendment have been extended to children both in what might be considered quasi-criminal proceedings, e.g., In re Gault, supra; Kent v. United States, supra, as well as in clearly non-criminal circumstances, e.g., Goss v. Lopez, supra. In Goss v. Lopez this Court specifically required that due process be provided to protect children's non-de minimis interests by holding that the state could not deprive a child of his statutorily derived right to attend school for even a few days without providing the child with notice and an opportunity to be heard. Hence, the applicability of the procedural safeguards of the Due Process Clause to the present case, where the threatened injury clearly exceeds the injury of a brief school suspension as in Goss v. Lopez, supra, should be readily apparent.

B. Several Bill of Rights Safeguards Are Implicated by Confinement of a Minor in a State Mental Institution.

Assuring the protection of due process rights in the present case is especially appropriate because commit-

ment to a mental institution is a "massive curtailment of liberty" for children as well as for adults. See Humphrey v. Cady, 405 U.S. 504, 509 (1972); Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968). Moreover, "liberty" is an "interest of transcending value," which affects numerous other constitutional interests of extreme importance. Speiser v. Randall, 357 U.S. 513, 525 (1958). Most obvious, perhaps, is the deprivation of the "right of free association, a right closely allied to freedom of speech and a right which, like free speech, lies at the foundation of a free society." Shelton v. Tucker, 364 U.S. 479, 486 (1960). "It is beyond debate that freedom to engage in association for advancement of beliefs and ideas is an inseparable aspect of the 'liberty' assured by the Due Process Clause of the Fourteenth Amendment, which embraces freedom of speech." N.A.A.C.P. v. Alabama ex rel. Patterson, 357 U.S. 449, 460 (1958). See De Jonge v. Oregon, 299 U.S. 353, 364 (1937).

Commitment to a mental institution also substantially affects the "right

to privacy" of children, a right which this court has sometimes referred to as the "right to be let alone." Stanley v. Georgia, 394 U.S. 557, 564 (1969). In recent years this Court has squarely held that this constitutional safeguard is applicable to children, as well as adults, protecting them against absolute or arbitrary prohibitions upon their decisions to prevent or terminate pregnancies. Carey v. Population Services International, 97 S.Ct. 2010 (1977); Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976). Also implicated are the minor's rights not to have his bodily integrity invaded by enforced administration of psychotropic medication,[2/] and his

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2/ Cf. Winters v. Miller, 446 F.2d 65 (2d Cir. 1971), cert. denied, 404 U.S. 980 (1971). The record herein reveals that plaintiff J. L. was treated by appellants with various drugs, including ritalin, amphetamine sulfate, navane, and numerous tranquilizers, but there was no consistent improvement in his condition (App. 96). In the 1973 Report of the Study Commission on Mental Health Services for Children and Youth, cited extensively by the district court below, the Commission found: "A high percentage of patients are on medication . . . . (footnote continued on next page)

reputation injured by being stigmatized as mentally ill.[3/]

2/ (continued from previous page)
It is not clear whether [medication is] . . . being used to implement individual treatment plans or to manage inappropriate behavior. Id. at 9.

3/ Cf. Goss v. Lopez, 419 U.S. 565 (1975). This interest in not being stigmatized is, in Amicus' view, especially signficant in light of the incontrovertible evidence that: "[t]he suspicion and mistrust that have surrounded mental illness since the time treatment first began by exorcising demons will haunt and hinder the expatient when he returns to society." Note, Civil Commitment of the Mentally Ill, 14 U.C.L.A. L.Rev. 822, 831 (1967). Besides the social ostracism involved, stigma from a mental commitment has a ". . . devastating effect on [the ex-patient's] employability." Calif. Assembly Subcomm. on Mental Health Services, The Dilemma of Mental Commitments in California, 57-9 (1972). Hence, the mental patient's interests which are affected by his commitment to a state hospital may even transcend the deprivations he suffers while confined. As one court has remarked, "the very livelihood of the individual may be at stake." In re Ballay, 482 F.2d 648, 668 (D.C. Cir. 1973).

II. THE INTERESTS WHICH THE STATE OF GEORGIA AND GEORGIA PARENTS SEEK TO VINDICATE DO NOT JUSTIFY MASSIVE CURTAILMENT OF APPELLEES' LIBERTY AND OTHER CONSTITUTIONALLY PROTECTED RIGHTS IN THE ABSENCE OF A JUDICIAL DETERMINATION THAT SUCH INTERVENTION IS APPROPRIATE AND NECESSARY.

As Amicus has demonstrated in Point I, supra, enforced confinement in a state mental institution constitutes a severe and pervasive infringement upon interests and values dearly cherished under our constitutional scheme. According to the due process analysis which has been adopted by this Court, interests which cannot be characterized as de minimus presumptively must be safeguarded by some type of prior due process hearing. See, e.g., Goss v. Lopez, 419 U.S. 565 (1975) (ten days of education); Morrissey v. Brewer, 408 U.S. 471 (1972) (parole revocation); Fuentes v. Shevin, 407 U.S. 67 (1972) (property attachment); Bell v. Burson, 402 U.S. 535 (1971) (revocation of driver's license); Goldberg v. Kelly, 397 U.S. 254 (1970) (termination of welfare benefits). These hearings are not required only in those limited

circumstances where: (a) there is no significant risk of erroneous deprivation of the protected interest; (b) there are adequate substitute procedural safeguards; or (c) the fiscal or administrative burdens caused by the due process requirements would be unduly onerous. Mathews v. Eldridge, 424 U.S. 319 (1976). See, Smith v. Organ. of Foster Families for Equality and Reform, ___ U.S. ___, 97 S. Ct. 2094 (1977).

As Amicus will demonstrate, infra, none of these exceptions apply in the present case. Without the protections afforded by an adversarial hearing, a serious risk exists, as the court below found, that children will be erroneously or inappropriately placed in state mental hospitals. 412 F.Supp. at 137-38. In Amicus' view, only through a judicial hearing procedure can the debilitating consequences of such inappropriate commitments be avoided. Hearings will facilitate the placements of minors who do not require hospitalization in non-institutional settings; and such procedures will maintain the fairness of the

process which, as this Court has remarked in a related context, may be as vital to the success of the treatment program as the treatment procedures themselves. In re Gault, 387 U.S. 1, 26 (1967).

As Amicus will also show, infra, there are no adequate, substitute procedures under Georgia law to safeguard the liberty and related interests of minors placed in state mental hospitals. There is no Georgia statute or regulation which requires referral of minors to a community mental health center for evaluation and diagnosis, and the state hospitals themselves are ill-equipped to expeditiously or accurately "screen out" those minors who do not require hospitalization. Finally, the fiscal and administrative burdens caused by these hearings, although not inconsiderable, will be far less onerous than burdens previously imposed by this Court in implementing the due process guarantee. See, e.g., Goldberg v. Kelly, supra; In re Gault, supra.

In Amicus' view the due process issue before this Court turns primarily

upon the balancing of interests asserted by the various parties implicated in the decision to place a child in a state hospital. These are the State, the child, and the child's parents or guardians. The child's interest in liberty, privacy, and freedom of association have already been discussed in Point I, supra. The State's interest is summarized by the Latin phrase parens patriae -- assuring the mental health of Georgia children. The parents also share this interest with regard to their own children; additionally, they have an interest in preserving the family unit and maintaining parental authority. See Bartley v. Kremens, 402 F.Supp. 1039, 1048 (E.D. Pa. 1975), vacated as moot, 97 S.Ct. 1709 (1977). Amicus will now discuss the interests of the State and the child's parents or guardians and demonstrate that none of these interests justify the abrogation of due process safeguards in the present case.[4/]

4/ It is also of some significance that these identical interests have been rejected, either explicitly or
(footnote continued on next page)

A. Assuring the Mental Health of Children.

1. At Common Law the Parens Patriae Authority of the Sovereign Was Not Exercised to Institutionalize the Mentally Ill.

One of the state interests which, allegedly, is being promoted by the Georgia voluntary commitment statutes[5] is the promotion and protection of the mental health of Georgia children. At common law the power of the King to act as guardian to promote the welfare of persons under legal disabilities was described by the term

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4/ (continued)
implicitly, as justifications for denying minors procedural rights in every reported decision examining the applicability of the Due Process Clause to the placement of minors in state mental institutions. In addition to the present case are: Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968); Bartley v. Kremens, supra; Kidd v. Schmidt, 399 F.Supp. 301 (E.D. Wis. 1975) (three-judge court); Saville v. Treadway, 404 F.Supp. 430 (M.D. Tenn. 1974) (three-judge court); In re Roger S., 19 C.3d 655, ___ Cal.Rptr. ___ (1977); In re Long, 25 N.C. App. 702, 214 S.E. 2d 626 (1975).

5/ Ga. Stats. Ann. §§88-503.1, 88-503.3(a).

parens patriae; in modern days this royal prerogative of the King has passed to the states. Hawaii v. Standard Oil Company, 405 U.S. 251, 257 (1972). The power of the state to intervene in the affairs of children and incompetents is usually justified on the basis that both groups are incapable of exercising mature judgment. See, Note, State Intrusion into Family Affairs: Justifications and Limitations, 26 Stan.L.Rev. 1383, 1392 n. 52 (1974).

What is significant for present purposes is recognition that at common law parens patriae was not invoked to justify actual confinement of the mentally ill. A person found to be a lunatic was ordinarily committed to the custody of a friend who received an allowance with which to care for the unfortunate person. See 1 Blackstone, Commentaries 305 (Hammond ed. 1890). Thus, having developed at a time when public institutions for the mentally ill were virtually non-existent, the parens patriae doctrine which developed at common law cannot now be used to justify confinement of the mentally

ill in institutions such as the mental hospitals we know today. See Lessard v. Schmidt, 349 F.Supp. 1078 at 1084-86 (E.D. Wis. 1972); vacated and remanded on other grounds, 414 U.S. 473 (1974); judg. reinstated, 379 F.Supp. 1376 (E.D. Wis. 1974); vacated and remanded on other grounds, 421 U.S. 957 (1975); judg. reinstated, 413 F. Supp. 1318 (E.D. Wis. 1976). Moreover, in colonial America, parents were expected to care for their own mentally disabled offspring. S. Brakel and R. Rock, eds., The Mentally Disabled and the Law 4 (1971). Hence, at common law and during the early stages of the history of this country, the authority of the sovereign to intervene parens patriae was not used to justify the more recent American innovation of using the Latin phrase to justify total, and in some cases permanent, loss of liberty. See Lessard v. Schmidt, supra, 349 F.Supp. at 1085; N. Kittrie, The Right to be Different: Deviance and Enforced Therapy 66 (1971).

In the juvenile sphere this Court has similarly traced the background of the state's purported power to deny

minors procedural rights available to adults. This Court's conclusion with regard to the state's parens patriae authority over juveniles parallels the conclusions which have been reached with regard to the historical basis for the state's power over incompetents: "The constitutional and theoretical basis for this peculiar system is -- to say the least -- debatable." In re Gault, 387 U.S. 1, 17 (1967).

2. This Court's Analysis in In re Gault, Disposes of Appellants' Parens Patriae Argument.

In recent years this Court has consistently rejected "civil labels," "good intentions," or "parens patriae" as justifications for denying criminal due process safeguards to minors in juvenile court. Breed v. Jones, 421 U.S. 519, 530 n.12 (1975); In re Winship, 397 U.S. 358, 365-66 (1969); In re Gault, 387 U.S. 1, 18, 19 (1967). Instead, this Court has measured the need for due process procedures against what it has termed the "reality" of institutional confinement. In re Gault, supra, 387 U.S. at 26-31. In Gault, this "reality" was described by Justice Fortas as follows:

> The boy is committed to an institution where he may be restrained of liberty for years. It is of no constitutional consequence -- and of limited practical meaning -- that the institution to which he is committed is called an Industrial School. The fact of the matter is that, however euphemistic the title, a 'receiving home' or 'industrial school' for juveniles is an instituton of confinement in which the child is incarcerated for a greater or lesser time. His world becomes a 'building with whitewashed walls, regimented routine and institutional hours . . . .' Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by guards, custodians, state employees, and 'delinquents' confined with him for anything from waywardness to rape and homicide. Id. at 27.

The institutional surroundings; the absence of the minor's most cherished companions, compelled association with persons who have committed deviant and anti-social conduct; the pervasive deprivation of individual liberty: it is these realities which impelled this Court to require extensive due process safeguards in Gault. Even the slightest familiarity with state mental institutions elicits recognition that this Court's description of

training school life in Gault is equally applicable to state mental institutions,[6/] and therefore, that the due process protections against unwarranted or inappropriate commitments mandated by this Court in Gault are essential to safeguard the integrity of the mental hospital placement process.

The lack of adequate treatment resources in most of our state mental institutions is so widespread that in Jackson v. Indiana, 406 U.S. 715 (1972), this Court recognized that the

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6/ "Recent studies -- notably those of Drs. Erving Goffman, William Caudill, and Ivan Belknap, based on prolonged ward observation -- attest to the continuance of the stripping of the patient, loss of his individuality and dignity, depersonalization, and demoralization. The chronically acute shortage of physicians in most wards makes the term 'psychotherapy' a hideous mockery for most patients. In most public mental hospitals, the average ward patient comes into person-to-person contact with a physician about fifteen minutes every month -- not a day or a week, but a month." Testimony of Dr. Albert Deutsch Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, pt. 1, 40, 43-44, 87th Cong., 1st Sess. (1961).

rationale for most pre-trial commitments of "incompetent" criminal defendants is dubious, ". . . given the state of most of our mental institutions." Id. at 734-35. In a case before a three-judge federal district court, Pennsylvania conceded that only three percent of the inhabitants of one of its state mental hospitals received any therapeutic-psychiatric treatment whatsoever. Dixon v. Attorney Gen'l of Penna., 325 F.Supp. 966, 969 (M.D. Pa. 1971).

In Georgia the Study Commission on Mental Health Services for Children and Youth indicated in its 1973 Report that at three of the five Georgia regional hospitals the staff believed that a majority of the children did not need to be hospitalized if alternative services were available in the community. Id. at A-5. The Commission found that many children are "not receiving individual or group therapy" and that interactions between children and the nursing staff "tended to be supervisory in nature rather than intensively therapeutic." Id. at A-10-11. The Commission questioned

whether the high percentage of patients on medication and frequent use of the seclusion room were attributable to the need to ". . . implement individual treatment plans or to manage inappropriate behavior." Id. at A-9. Finally, the Commission recommended that the eighty-bed adolescent unit at Central State Hospital -- where plaintiffs J. L. and J. R. have been confined -- should be closed, concluding: "It is a physical facility completely unacceptable for therapeutic rehabilitation of young people." Id. at 31.

The snake-pit conditions of most of our mental hospitals is so widespread as to have received almost universal recognition.7/ These

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7/ "[E]ighty percent of mental institutions are purely custodial providing no treatment of any significance even to their law abiding patients. . . . A good portion of the remaining twenty percent provide adequate treatment only for well-paying private patients." Schmideberg, The Promise of Psychiatry: Hopes and Disillusionment. 57 Nw. U.L. Rev. 19, 22 (1962). In a very recent book a distinguished physician concludes with considerable dismay: ". . . the state psychiatric facilities can, at best, be described as
(footnote continued on next page)

conclusions are supported by numerous studies which have found that varying methods of in-hospital treatment of psychiatric patients have not differentially affected discharged patients' functioning in the community as measured by recidivism, post-hospital employment, or any other suitable measure of behavior.[8/] Dr. Alan Stone of the Harvard Law School, who is perhaps the leading scholar in the country on the relationship between mental health and the law, has echoed these exact sentiments with regard to in-hospital psychiatric treatment

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7/ (continued)
medieval horrors and an offense to our civilization and a blot on psychiatry." Peskze, Involuntary Treatment of the Mentally Ill 67 (1975). "State mental hospitals suffer, perhaps, from more maladies than their inhabitants." Robitscher, The Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient, 18 Vill.L.Rev. 10, 11 (1972).

8/ The applicable literature is reviewed extensively in Schwitzgabel, The Right to Effective Mental Treatment, 62 Cal.L.Rev. 936 (1974). See Anthony, Buell, Sharott, and Althoff, Efficacy of Psychiatric Rehabilitation, 78 Psychological Bulletin 447 (1972).

of children. Stone, Mental Health and Law: A System in Transition, National Institute of Mental Health (DHEW Pub. No. (ADM) 75-176, 1975).[9/]

In In re Gault, supra, this Court reiterated its concern -- expressed earlier in Kent v. United States, 383 U.S. 541, 556 (1966) -- that children charged with the commission of delinquent conduct receive, "the worst of both worlds"; they get "neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children." In re Gault, supra, 387 U.S. at 18 n.23. Amicus believes that the

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9/ Professor Stone attributes the lack of available effective treatment for children to the following factors: "(a) Inpatient psychiatric facilities for children with rare exception have been horrendous. (b) Whatever the value of traditional diagnostic criteria may be they are not readily applicable to children, except in the case of profound illness. (c) Psychotherapeutic methods that do exist are geared to the intact family, and that is rarely the target group of the juvenile courts. (d) Finally, as Justine Wise Polier points out, the dollar and resource cost of the medical model approach is totally unrealistic." Id. at 146.

overwhelming weight of available evidence demonstrates that minors confined to state mental institutions are similarly: (a) subject to severe and massive deprivations of liberty; (b) often confined under conditions which can only be considered debasing and dehumanizing; and (c) receiving mere custodial care, rarely benefiting from any meaningful therapeutic treatment.

It is Amicus' position that as in Gault, supra, the institutional reality which greets minors who are processed through Georgia's "voluntary admission and commitment" system must be considered by this Court in determining whether due process protections must be provided. And because at the very least, there is considerable cause to question whether the legislative promise of "treatment" will be fulfilled,[10/] Amicus believes

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10/ 28 Ga. Code Ann. §88-503.1 authorizes placement of minors in state mental hospitals by their parents or legal guardians only if the superintendent of the hospital determines there is "evidence of mental illness" and the minor is "suitable for treatment."

that rigorous due process procedures are necessary to safeguard the rights of minors who may not require institutionalization. As in Gault, supra, these due process protections are especially appropriate because the minor plaintiffs in the present case: (a) are being processed through a special system lacking the procedures available to similarly situated adults; (b) are given no choice in the decision whether to continue treatment;[11/] (c) are being confined in order forcibly to provide them with treatment; (d) may be confined indefinitely until they attain their age of majority; and (e) will be released only when a discretionary determination has been reached that they are sufficiently "cured" or "rehabilitated" to warrant their return to society.

Appellants assert that the Gault due process analysis is inappropriate to this case. They note that in Gault

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11/ Under Ga. Code Ann. §88-503.3(a), the discharge of a minor patient, who was admitted on application of his parent or guardian, may be conditioned upon the consent of the parent or guardian.

this Court confined its consideration to delinquency proceedings which are basically quasi-criminal in nature.[12/] This distinction, if given determinative weight, paints Gault with too narrow a brush. As discussed earlier, this Court in Gault was concerned with far more than the quasi-criminal aspects of delinquency proceedings. If this Court's decision had turned solely upon the quasi-criminal nature of delinquency proceedings, there would have been no reason to focus at such length upon the realities and limitations of institutional treatment. Hence, this Court has not limited the application of the Due Process Clause to criminal or quasi-criminal proceedings. See, e.g., Goss v. Lopez, 419 U.S. 565 (1975); Stanley v. Illinois, 405 U.S. 645 (1972); Goldberg v. Kelly, 397 U.S. 254 (1970).

Appellants would convince this Court that the absence here of a legitimate police power interest in quasi-criminal conduct justifies a relaxation of due process rigor. Of course,

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12/ Brief for Appellants at 31.

the converse is true. Since the Georgia voluntary commitment scheme is premised soley upon the state's interest in promoting the health of its citizens, even greater vigilance is required to assure that persons are not being improperly denied their liberty.[13/] The absence of any requirement that commitment be based on specific conduct, combined with the absence of clear-cut statutory criteria for commitment, suggests the abuses to which such a vague statute may be subject. Minors who have committed no anti-social acts, and who do not wish to be confined in state mental institutions, surely have as much right as the alleged delinquents in Gault to demonstrate that the state has not satisfied the criteria it has established for their institutionalization and treatment. As this Court stated in Minnesota v. Probate Court, 309 U.S. 270 (1940):

13/ "Experience should teach us to be most on our guard to protect liberty when the Government purposes are beneficent." Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).

> We fully recognize the danger of a deprivation of due process in proceedings dealing with persons charged with insanity or, as here, with a psychopathic personality as defined in the statute, and the special importance of maintaining the basic interests of liberty in a class of cases where the law though 'fair on its face and impartial in appearance' may be open to serious abuses in administration and courts may be imposed upon if the substantial rights of the persons charged are not adequately safeguarded at every stage of the proceedings. 309 U.S. at 276-77.

Finally, the record in the present case reveals that a large number of minors admitted to Georgia state mental hospitals had committed delinquent or status offender conduct for which petitions could have been filed under the Georgia juvenile court law.[14/] The deposition of Dr. Luciano L'Abate, introduced at trial, noted the "tremendous overlap" in the types of behavior which result in minors being labelled mentally delinquent or

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14/ See, e.g., #832-00-1063 (runaway); #831-00-2543 (runaway); #831-00-3203 (car theft); #251-57-2450 (runaway); #834-00-0227 (chronic truancy); # D_____ (marijuana smoking); #800-209-308 (runaway). (App. 894-97).

mentally ill. App. 811. This is consistent with the finding in numerous case decisions that many children in state training schools would have been likely candidates for placement in mental hospitals, just as there are children in mental hospitals who might equally have been the subjects of juvenile court proceedings. See, Morales v. Turman, 383 F.Supp. 53, 88-89 (E.D. Tex. 1974), rev. 535 F.2d 864 (5th Cir. 1976), rev. and remanded 97 S.Ct. 1189 (1977) (372 juveniles in state training schools emotionally disturbed and 209 juveniles in these institutions had I.Q.'s lower than 70); Martarella v. Kelly, 349 F.Supp. 575, 591 (S.D.N.Y. 1972); Lollis v. New York State Dept. of Social Services, 322 F.Supp. 473 (S.D.N.Y. 1970). As one commentator has aptly noted,

> . . .[S]tandards of deviance and acceptability are relative. . . . The same behavior may, depending upon the situation, be considered socially acceptable, mentally ill, or criminal. . . .
>
> For example, an adolescent who commits a car theft may confess to a policeman, be called a juvenile delinquent and be jailed.

> He may instead consult a psychiatrist and then he is likely to be labelled mentally ill and receive psychotherapy. . . .
> J. Zusman, "Society and Mental Illness," 15 Arch. Gen. Psychiatry 635, 636-37 (1966).

Since the decision whether to commit a juvenile to a training school or place him in a State mental hospital will frequently depend -- not on the minor's behavior -- but rather on whether the minor is processed through the juvenile court or mental health systems -- Gault cannot be distinguished on the basis that it relates solely to quasi-criminal conduct. Georgia can no more readily fail to vouchsafe due process than could Arizona have circumvented Gault by legislating that parents could place their children directly in state training schools without the filing of juvenile court petitions. See Jackson v. Indiana, 406 U.S. 715 (1972) (state may not, consistent with Equal Protection Clause, create alternative procedures to accomplish same result, one of which lacks procedural safeguards afforded by the other); see also Baxstrom v. Herold, 383 U.S. 107 (1966).

B. Preserving the Family and Maintaining Parental Authority.

The principal interests which appellants assert in support of Georgia's voluntary commitment scheme are the preservation of the family unit and, especially, the maintenance of parental authority.[15/] Appellants note that the decision to provide a child

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15/ In the case of named plaintiff J. R., it is questionable whether appellants may assert these purported interests of his parents or guardians in support of the placement statute. J. R. was admitted to Central State Hospital upon application of the Georgia Department of Family and Children's Services with whom he had been placed by the juvenile court. 412 F.Supp. at 116. As this Court recently noted in Smith v. Organization of Foster Families, 45 U.S.L.W. 4638 (June 13, 1977), "[a]lthough the agency usually obtains custody in foster family care, the child still legally 'belongs' to the parent, and the parent retains guardianship." N.20 at 4641. "[F]or some crucial aspects of the child's life," "the agency has no authority to act." Ibid. In the case of J.R. the agency did possess the authority to seek his admission to Central State Hospital, but it did not thereby gain the right to assert the interests of plaintiff's parents or guardians as justification for denying him independent due process rights.

with medical care has traditionally been considered the prerogative of the child's parents. Appellants equate long-term institutionalization of a child in a mental hospital with, for example, forcing a child to share his room with siblings; and they conclude that both procedures should be treated by the law in a similar fashion. In support of their contention that the state may intervene in the affairs of the family only in the most limited circumstances, appellants cite Wisconsin v. Yoder, 406 U.S. 205 (1972); Prince v. Massachusetts, 321 U.S. 158 (1944); and Pierce v. Society of Sisters, 268 U.S. 510 (1925).

At common law children were treated generally as the property of their parents -- exercising few independent rights. A parent was considered the general guardian of the child's person even though the parent could not -- except in limited, well-defined circumstances -- dispose of the child's property. See Hoyt v. Hammekin, 55 U.S. 346 (1852); Maryland Casualty Co. v. Lawson, 110 F.2d 269 (5th Cir. 1940). It is sobering to recall that

only one hundred and three years ago the American Society for Prevention of Cruelty to Animals was empowered by the courts to act in a case of cruelty to a child on the basis that a child is an animal. Mitchell, The Child and Experimental Medicine, 1 Brit. Med. J. 721, 722 (1964).

In recent years, however, courts have increasingly recognized the constitutional rights of children. See, e.g., Goss v. Lopez, 419 U.S. 565 (1975); Tinker v. Des Moines Independent School District, 393 U.S. 503 (1969); In re Gault, 387 U.S. 1 (1967). Although these cases do not involve a direct conflict between the rights of children and the authority of their parents, these decisions treated children as independent entities exercising rights derived -- not from their parents -- but rather from their status as persons under the Consitution. In Gault, for example, this Court rejected the juvenile court rationale that a parent may be relied upon to protect the interests of the child. In re Gault, supra, 387 U.S. at 35.

Prior to its decision in Planned

Parenthood of Missouri v. Danforth, 428 U.S. 52 (1976), this Court had never decided a case squarely presenting a direct conflict between children's rights and parental authority. Hence, the prior decisions of this Court which are relied upon by appellants are inapposite because each involved solely a conflict between the power of the state and the authority of the parent. Referring to this line of authority, one court has correctly noted:

> . . . those cases which have considered parental control of children have involved conflicts between parents and the state wherein the courts have considered intrusions by the state into the area of parental values -- particularly religious values. Cases which have upheld parental control have not involved a situation where the parent and child differ and the state is imposing the parents' views on the minor. Foe v. Vanderhoof, 389 F.Supp. 947, 956 (D. Col. 1975). 16/

16/ In Foe v. Vanderhoof, supra, the court was referring in its decision specifically to Pierce v. Society of Sisters, Meyer v. Nebraska, and Prince v. Massachusetts, supra. Although not referred to explicitly, the (footnote continued on next page)

Although the conflict of interest between parent and child was not raised explicitly in any of these prior cases, it is certainly possible to read each of the decisions as vindicating not only the authority of the parent, but additionally, the rights of the child. Hence, Meyer v. Nebraska, 262 U.S. 390 (1923), had at least the practical effect of enhancing the opportunities for minors who had not graduated from the eighth grade to study modern foreign languages. Pierce v. Society of Sisters, 268 U.S. 510 (1925), of course, vindicated a parent's right to send her children to private school; but this Court also made it quite clear that it was protecting as well the right of children not to be forced to receive a "standardized" education. Id. at

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16/ (cont.)
district court's comment also applies to Wisconsin v. Yoder, supra, where this Court qualified its holding by stating: "Our holding in no way determines the proper resolution of possible competing interests of parents, children, and the State in an appropriate state court proceeding." 406 U.S. at 231.

535. In Wisconsin v. Yoder, 406 U.S. 205 (1972), this Court assumed, without deciding, that both Amish children and their parents preferred that the children receive a non-public education. And in Prince v. Massachusetts, 321 U.S. 158 (1944), this Court emphasized that society's concern for the welfare of its children

> . . . is no mere corporate concern of official authority. It is the interest of youth itself. 321 U.S. at 165.

Hence, although these decisions did not expressly resolve conflicts between children's rights and parental authority, this Court did recognize that the child's welfare is an independent interest warranting solicitude and protection.

In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976), this Court, for the first time, balanced the constitutional rights of children against the competing interests of their parents. This Court held that whatever interests a parent may have in the termination of his minor daughter's pregnancy were not more worthy of constitutional protection

than the minor's right to privacy. Accordingly, this Court invalidated the Missouri statute which had conditioned the minor's right to an abortion upon parental consent.

Planned Parenthood, supra, is instructive in several significant ways. First, this Court recognized explicitly that minors possess constitutional rights independent of their parents, and that these rights are entitled to be safeguarded even against competing claims by the minors' parents. In the present case, these rights include, not only privacy, but also the right of the minor not to be denied liberty without due process of law -- the constitutional safeguard which above all others distinguishes our system of orderly justice. See Grannis v. Ordean, 234 U.S. 385 (1914).

Second, in Planned Parenthood, this Court rejected the Attorney General's argument that requiring parental consent would be likely to further the state's interest in promoting family unity. 96 S.Ct. at 2844. Likewise, it must be seriously doubted whether vesting authority in parents

to place their children in mental hospitals without a judicial hearing is likely to promote family unity or harmony. The child who has no role in the commitment decision, is, as this Court has elsewhere recognized, unlikely to have confidence in the person or the system which refuses to accord him legitimate participation in decisions vitally affecting his interests. See, e.g., Breed v. Jones, 421 U.S. 519 (1975).

Third, this Court held that the constitutional deficiency in the Missouri statute rested in its imposition of an absolute limitation on the minor's right to obtain an abortion. As explained by Justice Stewart in his concurring opinion, the statute failed to provide for "prompt" judicial resolution of disagreements between parents and minors. It also failed to provide for judicial determinations as to the minor's ability to give informed consent without parental concurrence, or as to whether abortion would, in any event, be in the minor's best interests. 96 S.Ct. at 2850-51.

The Georgia statute under challenge in the present case suffers from similar deficiencies. It creates an absolute limitation on the minor's right not to be forcibly placed in a mental hospital. Under Ga. Stat. Ann. §88-503.1, the minor's wishes, maturity, and best interests are immaterial to the parent's placement decision.[17/]

Finally, it is essential to recognize that the dissenting opinions in Planned Parenthood, supra, rested upon a factual foundation inapplicable in the present case. In dissent, both Justices White and Stevens stressed the important function of parental counselling in ensuring that the

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17/ Bellotti v. Baird, 428 U.S. 192 (1976), which is relied upon by appellants, is simply inapposite to the case at bench. In Bellotti, supra, this Court did suggest that the Massachusetts abortion statute might be construed to obviate the constitutional problem presented by giving a parent a blanket veto over the child's decision to undergo an abortion. In the present case, by contrast, appellants are arguing that a blanket veto power identical in scope to the parental authority condemned in Planned Parenthood, supra, does pass constitutional muster.

minor's decision to terminate her pregnancy would be reasoned and well-considered. 96 S.Ct. at 2853 (separate opinion of White, J.); 96 S.Ct. at 2856-57 (separate opinion of Stevens, J.). The vital signficance of the parent's role as counselor was supported by evidence in Planned Parenthood, supra,[18] as well as in Bellotti v. Baird, 428 U.S. 132 (1976), that physicians and other persons who work at abortion clinics are unable to adequately perform this counselling function.

No similar state purpose is promoted by the Georgia scheme. First, it is questionable whether vesting commitment powers in persons other than the child, without recognizing the child's right to participate in the placement decision, would be likely to promote interchange between parent and child. Unlike the decision to terminate pregnancy, which is normally made at least initially by the minor, the decision to place a minor in a mental

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18/ 96 S.Ct. at 2851, n. 2 (Stewart, J. concurring).

hospital can, and under Georgia law frequently would, be made by a parent without prior consultation with his child. The purported mental illness of the minor would also be likely to discourage a parent from seeking the child's concurrence in the parent's commitment decision.

Second, assuming that some form of counselling would be desirable, a parent is not necessarily the appropriate person to perform that function. As more fully discussed in Part II B 3 and 4, infra, many parents are too intensely involved, either in a conflict of interest, or in the family's emotional difficulties, to serve as dispassionate advisors to their children. To the extent that the child's emotional problems are representative of broader familial dysfunction, the inappropriateness of the parent serving as counselor is self-evident.

Third, under the decision of the court below, the minor would have available to him an attorney;[19]

19/ Although the court below did not explicate the precise contours of a
(footnote continued on next page)

counsel could advise him as to both the legality and appropriateness of treatment in a mental hospital. This is a traditional role performed by the mental health bar, and would do much to ensure that the minor's decision to concur in, or to oppose, a placement in a mental hospital would be based upon the advice of a mature and neutral adult.

Finally, this Court recently decided Carey v. Population Services International, 97 S.Ct. 2010 (1977). Although Carey involved the State's, and not the parent's, power to prohibit distribution of contraceptives to anyone under sixteen years of age, this Court indicated that the two issues are analytically identical:

> Since the State may not impose a blanket prohibition or even a blanket requirement of parental consent [emphasis supplied], on

19/ (cont.)
due process hearing, other courts have assumed that provision of counsel is essential to ensure that the minor's right to be heard will be "meaningful." See, Bartley v. Kremens, supra, at 1050-51; In re Roger S., 19 C.3d 655, 672, ___ Cal. Rptr. ___ (1977).

> the choice of a minor to terminate her pregnancy, the constitutionality of a blanket prohibition of the distribution of contraceptives to minors is a fortiori [Emphasis in original.] foreclosed.
> 97 S.Ct. at 2021.20/

Seven justices of this Court21/ held, albeit on different theories, that the absolute prohibition upon minors under the age of sixteen obtaining contraceptives impermissibly infringed such minors' right to privacy. Carey is thus the logical extension of Planned Parenthood. Where a minor's constitutional rights are implicated, as in the present case, neither the State nor the minor's parents or guardians may impose absolute or arbitrary prohibitions or conditions upon their exercise.

Amicus does not question the general

20/ Four justice of this Court [Brennan, Stewart, Marshall and Blackman] held that where the State is impinging upon a constitutional right of the minor, it must establish that such restrictions serve a significant state interest. Id. at 2021.

21/ Justices Burger and Rehnquist dissented.

authority of parents as the persons best suited and primarily responsible for the rearing of their children. Indeed, parental authority, while not absolute (Prince v. Massachusetts, supra), is the cornerstone of our family structure. However, increasing recognition that children also have rights under our Constitution, even when those rights conflict with competing rights of their parents, as in Planned Parenthood, supra, requires a searching and sensitive examination of the interests and considerations pertinent to all parties.

Amicus believes that there are a number of significant, concrete factors which must be considered in determining when parental authority should be subject to judicial scrutiny. These include: (a) the nature and severity of the deprivation of the child's interests, and whether these interests are subject to constitutional protection; (b) the potential for harm to the child; (c) whether the parents' decision has the effect of preserving, or disrupting, the family structure; (d) the potential for conflict of

interest between parent and child; (e) the legitimacy in each situation of the normal presumption that a parent will act in his child's best interests; (f) the existence of non-judicial alternatives to safeguard the interests of the child; and (g) the child's capacity to make a competent and reasoned determination as to what is in his own best interest. When these factors are closely scrutinized, the necessity for judicial review of the parent's decision to seek commitment of his child is evident.

1. Minors Who are Inappropriately Confined in Mental Hospitals Are Subject to Severe Emotional and Psychic Harm.

As previously discussed,[22/] the decision to confine a child in a state mental hospital implicates a number of the child's constitutionally protected rights. Children who are inappropriately confined in mental institutions are especially subject to severe emotional and psychic harm. See Mathews v. Hardy, 420 F.2d 607, 611

22/ Part I, supra

(D.C. Cir.), cert. denied, 397 U.S. 1010 (1970); cf. In re Ballay, 482 F.2d 648, 667 (D.C. Cir. 1973). Providing judicial review of commitments would serve to ensure that only those minors who require hospital treatment will be institutionalized.

2. The Decision to Commit a Child to a State Hospital Necessarily Constitutes a Disruption of Family Harmony.

When a parent seeks to place his child outside of the family structure, he cedes some of his normal privilege to be free from state scrutiny. The state's ordinary reluctance to intervene in family affairs reflects an appreciation for the virtues in family autonomy. But when a parent removes a child from his family, and places him in a state institution, the sacrosanctity of family autonomy has already been breached by parental decision. There is no more reason to avoid judicial review of such a decision than there is of a parent's determination to place his child in a state training school, a local detention facility, or a juvenile camp. See In re Gault, supra; In re Roger S., supra, at 665.

Moreover, Amicus believes there is a qualitative difference between a parent's decision to seek medical treatment for his child, and his determination to commit his child to a mental institution. Medical care does not necessarily require hospitalization; but even if hospitalization is deemed necessary, institutionalization is ancillary to treatment. Mental commitments, on the other hand, are by definition custodial confinements. By their very nature such commitments are of indefinite duration and, frequently, are extensive in length. Given the absence of adequate treatment resources in many state hospitals,[23/] the custodial confinement may itself become the treatment. See Braginsky, Braginsky & Ring, Methods of Madness: The Mental Hospital as a Last Resort 179-80 (1969). And, to quote Justice Frankfurter, as a result of ". . . the uncertainty of diagnosis in this field and the tentativeness of the professional judgment." [Greenwood v. United States, 350 U.S. 366, 375

23/ See pp. 23-27, supra.

(1956)], the psychiatrist's decision as to when a patient should be released from a mental hospital would appear far less subject to a set of commonly accepted medical norms than, for example, the decision as to when a hospital shall discharge a patient following a hernia operation. Finally, as previously noted,[24/] the stigma of having been found "mentally disordered" transcends any opprobrium which might attach to hospitalization for non-therapeutic, medical reasons.

Notwithstanding these differences between treatment in medical hospitals and mental institutions, many courts have circumscribed the parent's right to make medical decisions for his child when the potential consequences to the child are sufficiently grave and/or there is reason to believe that the interests of the child are not being fully considered by the parent. Hence, it is now commonly accepted that where it is necessary to save the child's life, a court may authorize blood transfusions for a child, even

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24/ Note 3, supra.

over the First Amendment objections of parents who are Jehovah's Witnesses. See, e.g., State v. Perricone, 37 N.J. 463, 181 A.2d 751 (1962), cert. denied, 371 U.S. 890 (1962); People v. Labrenz, 411 Ill. 618, 104 N.E.2d 769 (Schaefer, J.), cert. denied, 344 U.S. 824 (1952). Courts will intervene in behalf of children even where there is no threat to the life of the child. In re Sampson, 29 N.Y. 2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972).[25/] And although the Supreme Court of Pennsylvania has ruled that the state does not have a sufficient interest to overrule a parent's religious objection to surgery when the child's life is not immediately imperiled, the court refused to uphold the parent's authority as against the wishes of their sixteen-year-old son. Instead, the court remanded for consideration of the boy's

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25/ Although in deciding In re Sampson, the New York Court of Appeals sought to distinguish its prior decision in In re Seiferth, 309 N.Y. 80, 127 N.E. 2d 820 (1955), relied upon by appellants, we submit that the effect of In re Sampson, concurred in by Chief Judge Fuld who had dissented in Seiferth, was to overrule the court's earlier case.

desires. In re Green, 448 Pa. 338, 292 A.2d 387 (1972).

3. The Ordinary Presumption That Parents Are Acting in Their Child's Best Interests Is Often Questionable When Parents Seek to Transfer the Responsibility of Caring for Their Children to the State.

Most medical decisions concerning children are appropriately left to the discretion of parents; but as we have observed, courts are not unwilling to intervene where the consequences to the child appear sufficiently grave -- especially when there is reason to believe that the child's wishes and interests, as distinguished from his parents', are not receiving ample consideration. Perhaps no other decision concerning the health of children warrants independent scrutiny as clearly as the decision to commit a child to a mental institution.

Where familial dysfunction occurs, it makes little sense to vest commitment power in one of the family members -- even a parent. Numerous studies and articles report that problem behavior in children is often symptomatic of ineffectual interpersonal relationships

among family members.[26] A response of some parents to severe family stress is to scapegoat their children, in some instances even institutionalizing them so that the parents will not have to deal directly with these problems.[27]

26/ See, e.g., Spiegel, The Resolution of Role Conflict Within the Family, in A Modern Introduction to the Family, 361-81 (N. Bell & E. Vogel eds. 1960); Vogel & Bell, The Emotionally Disturbed Child as the Family Scapegoat, in A Modern Introduction to the Family, supra, at 382-97; Carek, Hendrickson, and Holmes, Delinquency Addiction in Parents, 4 Arch. Gen. Psychiatry, 357-62 (1961); Marrow, Flexibility in Therapeutic Work with Parents and Children, 38 Bulletin of the Menninger Clinic, No. 2, at 129 (March 1974); Kreisman and Jay, Family Response to the Mental Illness of a Relative: A Review of the Literature, 10 Schizophrenia Bull. 34 (1974).

27/ One study reports that, from the parents' standpoint, scapegoating their children is not without utility. "For the parents, scapegoating served as a personality-stabilizing process. While the parents of these children did have serious internal conflicts, the projection of these difficulties onto the children served to minimize and control them. . . . From the point of view of the family, the primary function of scapegoating is that it permits the family to maintain its

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As for parents of mentally retarded youngsters, one commentator has enumerated some of the factors motivating

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27/ (cont.)
solidarity. . . . In all the disturbed families, very serious dissatisfactions between spouses came to light during the course of therapy. . . ." Vogel and Bell, The Emotionally Disturbed Child as the Family Scapegoat, in A Modern Introduction to the Family, 394-95 (N. Bell & E. Vogel eds. 1960).

See Ellis, Volunteering Children: Parental Commitment of Minors to Mental Institutions, 62 Cal.L.Rev. 840, 859-62 (1974); T. Scheff, Being Mentally Ill: A Sociological Theory 171 (1966) (noting a Philadelphia study which found that in 25 percent of the complaints of mental illness, it was the complainant, rather than the prospective patient, who showed signs of mental illness); Kaufman, et al., Treatment Implications of a New Classification of Parents of Schizophrenic Children, 116 Am.J.Psychiat. 620 (1960); Stabenau, et al., A Comparative Study of Families of Schizophrenics, Delinquents, and Normals, 28 Psychiatry 45 (1965) ("It has long been recognized that for many troubled parents, the most acceptable way to seek help for themselves is to seek it, instead, for their child. The overt wish to have the child treated masks, in very many cases, the covert wish of parents to have themselves treated. . . ."); Rinsley and Hall, Psychiatric Hospital Treatment of Adolescents, 7 Arch. Gen. Psychiat. 286, 287 (1962).

such parents to seek institutionalization of their children, including the interests of other children in the family, the mental and physical frustrations of the parents, hostility and economic strain resulting from the burden of caring for the children, and the parent's success-oriented expectations for their children. Murdock, Civil Rights of the Mentally Retarded: Some Critical Issues, 48 Notre Dame L. Rev. 133, 139-43 (1972). These considerations dramatize very real problems which confront parents of retarded or severely disturbed youngsters. The legal system, however, should not exalt the parents' difficulties over the children's needs by delegating an essentially unfettered power to parents who are in the midst of emotional turmoil.

The possibility that some parents seek to avoid the responsibility for caring for their children has not escaped judicial recognition. Dissenting in Kent v. United States, 401 F.2d 408 (D.C. Cir. 1968), Mr. Chief Justice (then Circuit Judge) Burger commented,

> Lawmakers in recent years have been sensitive to the need to

> make civil commitment difficult recognizing the danger of relatives 'farming' out their kindred into mental institutions for motives not always worthy. 401 F.2d 416 n.4.

In New York State Association for Retarded Children, Inc. v. Rockefeller, 357 F.Supp. 752, 762 (E.D.N.Y. 1973), the court admonished:

> There may be a fundamental conflict of interest between a parent who is ready to avoid the responsibility of caring for an abnormal child and the best interests of the child. [citation omitted].

And in a similar vein the North Carolina Supreme Court has concluded:

> The parent's admission of a child to a treatment facility may result from a variety of factors, and it is possible that not all of these factors stem from a legitimate concern for the child. [citation omitted]. In re Long, 25 N.C. App. 702, 214 S.E. 2d 626, 629 (1975).

Amicus is not contending that most parents who seek to commit their children are doing so for nefarious or ulterior reasons unrelated to what the parents perceive as the best interests of their children. The fact is, however, as the record below

demonstrates,[28/] some parents do have hidden agendas. Even the most well-intentioned parents may unconsciously attempt to shift the responsibility for their own or shared difficulties upon their children, while other parents may be responding hastily or unwisely to the pressure of familial dysfunction of which they are both a participant and a cause. It is difficult for parents to make rational choices when they feel the pressure of family problems, especially when the decision to place a child in a state mental hospital entails an expertise about the treatment of mental illness, and the existence of less intrusive methods of treatment, which the ordinary parent will usually not possess.

28/ See, e.g., deposition of Dr. Eli Messinger (App. 163-168); Deposition of Dr. John Filley, Director of the Office of Child and Mental Health Services, Atlanta Division ["The problem here in part is the history and tradition of mental hospitals which have been dumping grounds in the past. . . . there are a lot of people who still treat them as dumping grounds." (App. 768); Deposition of Dr. Luciano L'Abate (App. 799-805).

4. Children and Parents Who Disagree as to the Appropriateness of Institutionalization are in a Position of Fundamental Conflict of Interest.

There is, therefore, manifest potential for conflict of interests when parents seek the commitment of their children to mental hospitals. Where such potential conflicts exist, courts have not been reluctant to act in order to safeguard the independent interests of the child.[29/] Due process procedures

29/ See, e.g., McBridge v. Jacobs, 247 F.2d 595 (D.C. Cir. 1957) (parent may not waive minor's right to counsel); Horacek v. Exon, 357 F.Supp. 71 (D. Neb. 1973) (separate guardian ad litem appointed to represent children suing to remedy conditions in state home for retarded); State v. Wade, 527 P.2d 753 (Ore. App. 1974), appeal dismissed, 96 S.Ct. 16 (1975) (because of potential conflict in all parental termination proceedings appointment of separate counsel for children is mandatory); Melville v. Sabbatino, 30 Conn. Supp. 320, 42 U.S.L.W. 2242 (1973) (minors over age of 16 can sign themselves out of mental hospitals even if their parents have admitted them); In re Henry G., 28 Cal.App. 3d 276, 104 Cal.Rptr. 585 (1972) (error to preclude minor's counsel for inquiring into whether alleged breakdown in parental control resulted from mother's failings); In re Smith, 16 Md. App. 209, 295 A.2d

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are the preferred and appropriate mechanism for ensuring that the best interests of the child will be considered independently of his parents' desires. The child's fate should not be clouded by a variety of parental pressures and concerns which, although pertinent to the treatment inquiry, ought not be dispositive. See Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968); Saville v. Treadway, supra; In re Long, supra.

5. No Uniform Procedure Exists Under Georgia Law Which Provides an Adequate Substitute for a Due Process Hearing.

Unlike many jurisdictions,[30/] Georgia

29/ (cont.) 238 (1972) (minor's mother has no power to compel minor to undergo abortion against her will); In re Anonymous, 42 Misc. 2d 572, 248 N.Y.S. 2d 608 (Nassau Co. Ct. 1964) (adoptive parent's application to commit ten-year-old child to mental hospital denied because minor's hallucinations caused by rejection of adoptive parents); In re Sippy, 97 A.2d 455 (Ct. of App., D.C. 1953) (where interests of mother and minor are sharply opposed regarding commitment of the minor to a "psychiatric school," the mother's attorney cannot purport to represent the minor.)

30/ See Bartley v. Kremens, supra, n.5 1042; In re Roger S., 19 C.3d 655, n.5 666, ___ Cal.Rptr. ___ (1977).

does not require that before a minor may be admitted to a state hospital, he must be evaluated and tested by a community mental health center. The record contains numerous references to the divergent practices among the various regional hospitals in Georgia,[31/] and appellants have been unable to point to any state law or regulations requiring such a procedure of prior screening and evaluation. Although, for reasons to be developed, infra, Amicus has serious doubts about the adequacy of even a mandatory screening program at the community level, it is important to recognize that Georgia

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31/ Deposition of Drs. John J. Gates and W.T. Smith (community mental health program "[t]o some degree" plays a role in the admission policy of Central State Hospital) (App. 280); Deposition of Dr. Wladyslaw Piotr Mazur (If request comes from family, evaluation conducted by staff at West Central Georgia Regional Hospital; patients referred by mental health clinics are screened by clinics and evaluated at hospital.) (App. 479); deposition of Dr. James B. Craig (Emergency cases admitted directly by Regional Hospital in Savannah; non-emergency cases screened by mental health center.) (App. 522-23).

lacks such a uniform procedure which would, at least, tend to increase the number of minors being referred to community mental health programs with which the centers are more familiar than the regional hospitals.

The sole substitute to a due process hearing which is required under Georgia law is the diagnosis and observation of the patient which occurs at the regional hospitals after the minors have been admitted. Ga. Code Ann. §88-503.1. However, the recent literature which Amicus has reviewed raises considerable question as to the ability of psychiatrists, not only to predict dangerousness, but even to agree in their most gross psychiatric diagnoses.[32/]

32/ See Rosenhan, On Being Sane in Insane Places, 13 Santa Clara Law. 379 (1973) (8 sane persons, feigning mental illness, were admitted to mental hospitals and diagnosed as schizophrenic or manic-depressive; when released, none of the persons was considered by the hospital staff to be cured.) Ennis and Litwack have reviewed the pertinent literature exhaustively and conclude that if a psychiatrist testifies that a patient falls into a specific, non-organic diagnostic category, ". . . it is more

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Given the demonstrable unreliability of psychiatric diagnosis, even under optimum conditions, such a relatively crude instrument may not be relied upon as the essential protector of the

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32/ (cont.)
likely than not that a second psychiatrist would disagree." Ennis and Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Cal.L.Rev. 693, 702 (1974). In one experiment, twenty-seven experienced psychiatrists, all members of the same hospital, used a standardized set of statements to rate patients presented to them in a half-hour filmed interview. The psychiatrists ". . . were unable to agree as to the patient's diagnosis, prognosis, psychodynamics, the cause of her problems, the feelings she was consciously experiencing or the feelings that were latent . . ." Stoler and Geertsma, The Consistency of Psychiatrists' Clinical Judgments, 137 J. of Nerv. Mental Dis. 58, 64 (1963). In still another study, two skilled psychiatrists diagnosed twenty hospital patients for depression. Both psychiatrists labeled six of the twenty patients as depressed, but they did not choose the same six! Cherry and Cherry, The Common Cold of Mental Ailments: Depression, New York Times Magazine, Nov. 25, 1973 at 38; see Roth, Dayley and Lerner, Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes, 13 Santa Clara Law. 400 (1973).

minor's liberty.

Another major problem is that Ga. Code Ann. §88-503.1 only requires the superintendent of the hospital to find "evidence of mental illness" and that the minor is "suitable for treatment." It would appear that the statute does not even require a finding that the minor suffers from a mental disorder; but even assuming arguendo the statute is construed this narrowly, it fails to distinguish between those persons who would benefit from psychiatric treatment and those who require institutionalization.33/ Placing

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33/ A number of courts have invalidated mental commitment standards which were based upon a determination as to whether a person is in need of care or treatment. These courts have insisted that involuntary confinements to mental institutions be limited to persons who have shown a propensity for harm to themselves or others. Bell v. Wayne County Gen. Hosp. at Eloise, 384 F.Supp. 1085 (E.D. Mich. 1974) (three-judge court) (imminent threat of physical harm to prospective patient or others); Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974) (three-judge court) (overt act showing real and present threat of substantial harm to prospective patient or others); State ex rel. Hawks v. Lazaro, 202
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only the psychiatrists between the parent and hospitalization of the child, the Georgia scheme does nothing to protect against the unnecessary hospitalization which is certain to occur given the inadequacies of the psychiatric diagnoses referred to above. Moreover, these inadequacies in diagnoses are made more serious by the utter lack of standards under Georgia law to govern placement of minors in mental hospitals. Hence, the Georgia scheme provides only an unsystematic, haphazard, and largely ineffectual check upon parental discretion.

It is also important to recognize the conditions under which psychiatrists in mental hospitals evaluate the children for possible commitment purposes. As Professor Stone has noted,

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33/ (cont.)
S.E. 2d 109, 123 (W. Va. 1974) (self-destructive urge or person will permit himself to die of starvation or lack of care); Commonwealth ex rel. Finken v. Roop, 234 Pa. Super. 155, 339 A.2d 764 (1975) (overt act raising substantial likelihood of future dangerous acts); see Humphrey v. Cady, 405 U.S. 504, 509 (1972) (dicta).

> The feeling of crisis which attends the process of emergency confinement rarely permits the full exploration of the patient's competence.
> Stone, Mental Health and Law: A System in Transition 48, National Institute of Mental Health (DHEW Publ. No. (ADM) 75-176, 1975).

Not only are many mental hospitals understaffed[34/] but equally significant, most physicians:

> learn early in their training that it is far more culpable to dismiss a sick patient than to retain a well one.
> Scheff, Being Mentally Ill: A Sociological Theory 110 (1966).

This has led to the conservative bias of almost all psychiatrists in favor of over-diagnosing mental illness,[35/]

34/ Mechanic, Some Factors in Identifying and Defining Mental Illness, 46 Mental Hygiene 66 (1962).

35/ Scheff conducted a study of mental commitments drawn from psychiatrists' ratings of a sample of patients newly admitted to public mental hospitals in a Midwestern state. He found that in two-thirds of the hospitals the examinations were perfunctory and virtually never resulted in findings of health. In some instances the decision to retain a patient was reached even when no evidence of any mental disorder could be found. Scheff, Being Mentally Ill: A Sociological Theory 142, et seq. (1966).
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as contrasted with the criminal law's presumption that defendants are both innocent and sane. It is understandable that a physician trained in treating illness would prefer to commit a healthy person to a mental hospital rather than allowing a mentally ill person to go free, but such a practice is hardly consistent with the constitutional guarantee that liberty shall not be infringed without due process of law.

Finally, given the inherent bias of the psychiatrist in favor of finding illness, and the time and resource

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35/ (cont.)
Mechanic reports that in two mental hospitals studied over a period of three months he ". . . never observed a case where the psychiatrist advised the patient that he did not need treatment. Rather, all persons who appeared at the hospital were absorbed into the patient population regardless of their ability to function adequately outside the hospital." Mechanic, Some Factors in Identifying and Defining Mental Illness, 46 Mental Hygiene 66, 70 (1962). Brown has referred to the practice of large state mental hospitals which admit "everyone sent for hospitalization." E. L. Brown, Newer Dimensions of Patient Care, pt. I, at 60 (1961).

constraints upon the initial evaluation, the fact that a parent has decided that a child is sufficiently mentally ill to warrant his institutionalization is likely to substantially predispose the physician to join in the parent's appraisal.36/ Even a physician who questions the parent's evaluation is likely to approve the commitment in order to provide sufficient time for a thorough examination and diagnosis. Once the child is present in the mental institution, there is considerable evidence that he may adopt the "deviant" behavior of other patients as his own, thus confirming the institution's diagnosis.37/ And even if

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36/ "[W]here the parent admits a child for treatment, the examining doctor may quite naturally identify with the interest of the parent. If [this] happen[s], the doctor would be unable to act effectively as a screening agent at the initial stage of examination." In re Long, 25 N.C. App. 702, 214 S.E. 2d 626, 629 (1975); see Scheff, Being Mentally Ill: A Sociological Theory 149 (1966).

37/ See E. Goffman, Characteristics of Total Institutions, in Symposium on Preventive and Social Psychiatry (1957): H. Dunham and S. Weinberg, The Culture of the State Mental Hospital (1960).

evaluation ultimately results in the minor's discharge, he already will have suffered a considerable deprivation of liberty warranting due process protection. See, e.g., Bell v. Burson, 402 U.S. 535 (1971); Black Coalition v. Portland School District No. 1, 484 F.2d 1040 (9th Cir. 1973).

6. Mature, Competent Adolescents, Who Are Capable of Fully Understanding the Consequences of Their Actions, Should Not Be Disqualified from Participating in the Judicial Process Simply Because They are Minors.

Amicus believes that a final factor which should be accorded substantial weight in any decision affecting vital interests of a child is the child's capacity to arrive at mature, intelligent, and competent decisions about what is in his best interests. Because these considerations are also of crucial importance in determining the extent to which hearings must be afforded minors under an equal protection analysis, Amicus will explore the applicability of these factors separately in Point III, infra.

III. EVEN IF ALL MINORS IN GEORGIA ARE NOT ENTITLED TO FULL DUE PROCESS HEARINGS, THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT REQUIRES THAT MINORS AGE FOURTEEN AND OLDER RECEIVE COMMITMENT HEARINGS COMPARABLE TO THOSE AVAILABLE TO ADULTS.

Amicus has previously asserted that all minors are entitled to due process hearings irrespective of age. Even if, arguendo, this Court rejects the views which Amicus has thusfar presented, Amicus strongly believes that Georgia minors who are over the age of thirteen must, both as a matter of sound judicial policy and under an equal protection analysis, be accorded mental commitment hearings comparable to those available to adults.

Legislative distinctions between adults and minors have generally been posited upon the assumption that minors lack the maturity and judgment necessary for making independent decisions. See Carey v. Population Services, supra, n.15 2021; Planned Parenthood, supra, at 102 (Stevens J. conc. and diss.). At the same time, courts have increasingly recognized that, for older minors particularly, "Constitutional

rights do not mature and come into being magically only when one attains the state-defined age of majority." Planned Parenthood, supra, at 2843. Indeed, in Planned Parenthood, this court specifically recognized that any independent interest which a parent may have in terminating his minor daughter's pregnancy must yield to the privacy right of "the competent minor mature enough to become pregnant." [Emphasis supplied.] Id. at 2844.[38]

The ability of older, mature minors to reach reasoned conclusions as to what is in their best interests has been recognized for many years in

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38/ It is possible to attribute the different results reached by this Court in such cases as Carey v. Population Services International, 97 S.Ct. 2010 (1977), and Planned Parenthood, supra, on the one hand, and Ingraham v. Wright, 51 L.Ed. 2d 711 (1977), and Smith v. Organ. of Foster Families for Equality and Reform, 97 S.Ct. 2094 (1977), on the other, in part to differences in the ages of the children affected by this Court's decisions. Children who are capable of conceiving a child constitute a self-limiting class of older minors, whereas school children and foster children include minors of all ages.

jurisdictions which follow the so-called "mature minor rule." The cases which follow this exception to the common law doctrine that parental consent is required for non-emergency medical treatment of minors hold,

> . . . when the minor has sufficient mental capacity and maturity to understand the nature and consequences of the medical procedure or treatment undertaken for his or her benefit, the minor's consent to treatment will be legally sufficient.
> Pilpel and Zuckerman, Abortion and the Rights of Minors, 23 Case West.Res.L.Rev. 779, 783 (1972)[39]

39/ See, e.g., Younts v. St. Francis Hosp. and School of Nursing, Inc., 205 Kan. 292, 301, 469 P.2d 330 (1970); Gulf and S.I.R. Co. v. Sullivan, 155 Miss. 1, 10, 119 So. 501 (1928); Lacey v. Laird, 166 Ohio St. 12, 14, 139 N.E. 2d 25 (1956); Bishop v. Shurly, 237 Mich. 76, 78-79, 211 N.W. 75, 85-86 (1926); Bach v. Long Island Jewish Hosp., 49 Misc. 2d 207, 267 N.Y.S. 2d 289 (Sup. Ct. 1966); see also W. Prosser, Torts, §18 at 103 and n.51 (4th ed. 1971); Restatement of Torts §59(a) (1934); Bennett, Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis, 62 Va.L.Rev. 285 (March 1976); Institute of Judicial Administration-American Bar Ass'n, "Juvenile Justice Standards Project", Standards Relating to Rights of Minors (Tent. Draft 1977) §4.6.

The "mature minor rule" is also consistent with the overwhelming consensus of developmental psychologists that a child of twelve or thirteen years of age has begun to develop significant mental capacity which, by age sixteen, is firmly established.[40/]

Recently, in Bellotti v. Baird, 428 U.S. 132 (1976), this Court remanded a case to afford the Supreme Judicial Court of Massachusetts an

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40/ The person who has pioneered in this area has concluded that qualitative changes in the direction of adult thought begins at age 12-13. J. Piaget, The Moral Judgment of the Child (1932). See Note, State Intrusion into Family Affairs: Justifications and Limitations, 26 Stan.L.Rev. 1383, 1395-97 (1974): "Beginning in early adolescence, the child is able to deal with abstract concepts and ideals such as love, equality, and society [citing J. Hill and J. Shelton, Readings in Adolescent Development and Behavior 84 (1971)], and to anticipate and evaluate future consequences." 26 Stan.L.Rev., supra, 1395 n.66. See Adelson and O'Neil, Growth of Political Ideas in Adolescence: The Sense of Community, 4 J. Pers. and Soc. Psychol. 295 (1966). By age 16 the cognitive transformation is basically completed and adult mental operations are firmly established. See Elkind, Egocentrism in Adolescence, 38 Child Develop. 1025, 1032 (1967).

opportunity to construe its abortion statute in order to determine, inter alia, whether the mature minor rule is applicable. When the Supreme Judicial Court of Massachusetts indicated that the mature minor rule is applicable only to medical procedures other than abortions [Baird v. Attorney General, 360 N.E. 2d 288, 294-96 (1977)], the three-judge court promptly stayed the state court's decision. Baird v. Bellotti, 428 F.Supp. 854 (D.Mass. 1977). The court stated that it would have to determine whether the mature minor rule is a constitutional requirement in order to mollify "otherwise impermissibly harsh effects of [the] statute." Id. at 856-57.

Amicus believes that no "significant", or even rational, state interest is served by Ga. Code Ann. §§88-503.1 and 88-503.3(a) which deny to mature minors, capable of exercising their rights with intelligence and understanding, the same hearing which is available to even incompetent or mentally retarded adults. See Carey v. Population Services International, supra, n.15 2021. Even if, arguendo, Georgia

could summarily commit adults to state mental hospitals, it may not, consistent with the Equal Protection Clause of the Fourteenth Amendment, draw distinctions based solely upon age when age is tenuously related to the determinative factors of maturity, competence, and understanding.[41] Cf. Eisenstadt v. Baird, 405 U.S. 438 (1972). By creating an all-inclusive, irrebutable presumption that minors are incapable of intelligently choosing whether they desire to be hospitalized, the Georgia procedure,

> . . . forecloses the determinative issues of competence and care . . . [and] needlessly risks running roughshod over the important interests of both parent and child. Stanley v. Illinois, 405 U.S. 645, 657 (1972).

In recent years both Congress and state legislatures have increasingly

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41/ It is interesting to note that under the Georgia statutes challenged in this Court even minors who demonstrated the traditional indicia of emancipation, such as marriage, induction into the armed services, or a domicile separate from their parents [see Standards Relating to Rights of Minors, supra, Commentary to §2.1(c), p. 27] are not entitled to any type of precommitment hearing.

recognized that minority is not synonymous with maturity, and that the traditional notion that minors are lacking in legal rights must yield to a more flexible rule which considers, not only the age of the minor, but also the purpose of the legislative enactment. Since the passage of the 26th Amendment, at least thirty-three state legislatures have lowered their age of majority to eighteen. Arnoff, What Lawyers Should Know About the New Age of Majority, 46 Ohio Bar 1551 (Nov. 1973). Almost all jurisdictions have provisions which authorize juvenile courts to transfer minors to criminal courts for adult prosecution. See Breed v. Jones, 421 U.S. 519 (1975); Kent v. United States, 383 U.S. 541 (1966).[42] Many state legislatures have enacted laws enabling minors to consent to medical treatment for various problems, including treatment for drug abuse or dependency. Katz, Schroeder, and Sedman, Emancipating our Children --

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42/ A compilaton of these statutes is contained in Stamm, Transfer of Jurisdiction in Juvenile Courts, 62 Ken. L.J. at 122 at n.6 126 (1973).

Coming of Legal Age in America, 7 Family Law Quarterly 211, 238-39 (Fall 1973); Pilpel, Minors' Right to Medical Care, 36 Albany L. Rev. 462 (1972). Amicus has annexed to this brief as Appendix A a table which sets forth for each state the maximum age of juvenile court jurisdiction, the minimum age for waiver to criminal court, the age of criminal responsibility, the age of majority, the age of eligibility for marriage, and the age at which a child must consent to adoption. This table demonstrates conclusively that each state delegates significant responsibility to minors consistent with their age and the state policy underlying the legislative enactment.

Amicus is not asking this Court to legislate for the entire nation a minimal age at which children are entitled to full due process hearings before they are admitted to state mental hospitals. Amicus does believe, however, that it is both appropriate and necessary for this Court to look to the enactments of state legislatures to determine if those governing bodies have specified sufficient indicia

of competence and responsibility so that a minimal age must be judicially imposed as a matter of equal protection. This approach is consistent with the analysis undertaken recently by Justice Powell in Carey v. Population Services International, supra, where Justice Powell found that since New York had authorized marriage at age fourteen, it is presumed that husbands and wives of that age, ". . . possess the requisite understanding and maturity to make decisions concerning sex and procreation." 97 S.Ct. at 2028.

Amicus believes that for most jurisdictions the significant age to look to is the age of criminal responsibility.[43/] At common law a child fourteen years of age of older was presumed conclusively to have the

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43/ The Commentary to the National Institute of Mental Health's Draft Act Governing Hospitalization of the Mentally Ill (Pub. Health Services Pub. No. 51, 1951) argues that the age at which persons should be able to seek hospitalization on their own initiative or, once hospitalized, request their own release, should be based upon their responsibility for criminal conduct or their legal capacity to consent to surgery.

criminal responsibility of an adult.[44] Children fourteen years of age or older were considered no longer of "tender years" because they had the same capacity as adults to distinguish right from wrong.[45] As noted recently by the California Supreme Court,

> Traditionally, and modernly by statute, minors have been presumed competent to accept responsibility for criminal acts at age 14. [Citations omitted.] It would be anomalous indeed if they were not also presumed to have sufficient capacity to exercise due process rights at that age.
> In re Roger S., 19 C.3d 655, 665-66, ___ Cal.Rptr. ___ (1977).

In Georgia the age of criminal responsibility is thirteen. Ga. Code Ann. §26-701. Under the equal protection analysis undertaken by Amicus, age thirteen presumptively is the age at which minors should be entitled to full pre-commitment due process hearings.

44/ LaFave and Scott, Criminal Law 351-52 (1972); Kean, History of Criminal Responsibility of Children, 53 L.Q. Rev. 364 (1937).

45/ Odgers and Odgers, The Common Law of England, n.1 1369 (2d ed. 1920); 4 Stephen, Commentaries on the Law of England, 24-26 (10th ed. 1886).

However, Amicus also believes that other state statutes relating to rights and responsibilities of minors should be consulted. Under Ga. Code Ann. §88-503.1(b) a superintendent of a state hospital may receive a minor fourteen years of age or older who makes application for admission, subject to the parent or guardian's later application for discharge of the minor. Since the Georgia legislature has determined that minors age fourteen or older possess sufficient mental ability and understanding to seek their own commitments to state mental hospitals, it defies rationality to delegate to the parents or guardians an unfettered power of disaffirmance. Cf. Melville v. Sabbatino, 30 Conn. Supp. 320, 42 U.S.L.W. 2242 (1973) (minors over age sixteen can sign themselves out of mental hospitals even if their parents have admitted them).

A review of other Georgia statutes confirms the proposition that at age fourteen minors in Georgia are vested with extensive rights and responsibilities.[46] Amicus urges this Court,

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46/ (see next page)

if it is unwilling to grant full due process hearings to all minors, to look to the age distinctions which have been created by the Georgia Legislature. A review of these statutes leads to the conclusion that Georgia minors fourteen years of age or older are considered capable of exercising mature judgment, and should be granted the same hearing procedures which Georgia has made generally

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46/ (from previous page) See, e.g., Ga. Code Ann. §§24A-1701 and 81-212 (service in civil and juvenile court proceedings must be made personally upon minors over age of 14); Ga. Code Ann. §24A-2501 (minors 15 or older may be transferred for criminal prosecution; minors 13 or 14 may be waived if they are charged with committing acts for which punishment is loss of life or life imprisonment); Ga. Code Ann. §24A-3503 (children 13 or older may be fingerprinted); Ga. Code Ann. §49-105 (children 14 or older may select own guardian); Ga. Code Ann. §127 (children 14 or older may, in child custody proceeding, select parent with whom children desire to live; this selection controlling unless parent found unfit); Ga. Code Ann. §54-301 (children 14 or older not subject to child labor laws); Ga. Code Ann. §74-104.3 (children of any age may consent to treatment for venereal disease or drug abuse).

available to adults.

CONCLUSION

For the foregoing reasons, Amicus urges that this Court affirm the judgment below; or, alternatively, modify the judgment in accordance with the reasons set forth in Point III of this brief.47/

Dated: San Francisco, California
September 8, 1977

Respectfully submitted,

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THE CHILD WELFARE
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47/ Counsel for Amicus wishes to express his appreciation for the assistance of Peter Beckwith, a third year student of Boalt Hall School of Law, in the preparation of this brief.

APPENDIX A

STATE	Maximum Age of Juv. Ct.; Juris., Non-Traffic Crimes	Minimum Age for Waiver to Adult Criminal Court	Age of Criminal Responsibility	Age of Majority	Age of Eligibility for Marriage	Age at and Above Which Child Must Consent to Adoption
ALABAMA	16[1]	14	14	19	19; with PC--17-m, 14-f	No Provision
ALASKA	17	7[2]	14[2]	19	19; with PC & CC-16-m, 14-f	10, WBC
ARIZONA	17	No Min. Age[3]	14	18	18; with PC & CC-16-m & f	12, WBC
ARKANSAS	17	No Min. Age[4]	14	18	18; with PC-17-m, 16-f	14
CALIFORNIA	17	16 (fel.)	14	18	18; with PC & CC-any age	12
COLORADO	17	14 (fel.)	10	18	18; with PC-16; with PC & CC-under 16	12
CONNECTICUT	15	14 (fel.)	16[5]	18	18; with PC-16; with CC-under 16	14
DELAWARE	17	16 (fel.)	16	18	18; with PC-16-f	14, WBC
DISTRICT OF COLUMBIA	17	16[6]	16	18	18; with PC-under 18	14
FLORIDA	17	14[6]	[7]	21	21; with PC-under 21	12

PC - Parental Consent; CC - Court Consent; m,f - male, female; WBC - Consent Waivable by Court.

STATE	Maximum Age of Juv. Ct.'s Juris., Non-Traffic Crimes	Minimum Age for Adult Court Waiver to Criminal	Age of Criminal Responsibility	Age of Majority	Age of Eligibility for Marriage	Age at and Above Which Child Must Consent to Adoption
GEORGIA	16	15 13 - If capitol crime	13	18	18; with PC-16	14
HAWAII	17	16	16[8]	18	18; with PC-16; with PC & CC-15	10, WBC
IDAHO	17	16	14	18	18; with PC-16; with PC & CC-under 15	No provision
ILLINOIS	16	13	13	18	18; with PC-16; with PC & CC-15	14
INDIANA	17	14	14[9]	18	18; with PC-17; 15-17-f (pregnant)	14
IOWA	17	14	14[9]	18 or Marriage	18; with PC-16	14
KANSAS	17	16	16[9]	18	18; with PC-under 18	14
KENTUCKY	17	16 (fel.)	16[10]	18	18; with PC-under 18	12, WBC
LOUISIANA	16	15	10	18	18	No provision

STATE	Maximum Age of Juv. Ct.'s Juris., Non-Traffic Crimes	Minimum Age for Adult Court Waiver to Criminal	Age of Criminal Responsibility	Age of Majority	Age of Eligibility for Marriage	Age at and Above Which Child Must Consent to Adoption
MAINE	17	Any Age	18[11]	18	18; with PC, under 18	14
MARYLAND	17[12]	14[13]	17[11]	18	18; with PC-16, unless pregnant	10
MASSACHUSETTS	16	14	14[10]	18	18; with PC-under 18	12
MICHIGAN	16	15 (fel.)	15[9]	18	18; with PC-16-f	10
MINNESOTA	17	14	14[14]	18	18; with PC-16-f	14
MISSISSIPPI	17	13 (fel.)	13	21[15]	17-m;15-f; PC-if younger	14
MISSOURI	16	14	14[9]	21	18; with PC & CC-15	14
MONTANA	17	16[16]	14	18	18; with PC & CC-16	12
NEBRASKA	17	16[17]	14[2]	19	19	No provision
NEVADA	17	16 (fel.)	14	18	18; with PC-16; PC & CC-under 16	14
NEW HAMPSHIRE	17	Any age (fel.)	14[2]	18	18; with PC-14-m; 13-f	12

STATE	Maximum Age of Juv. Ct., Juris., Non-Traffic Crimes	Minimum Age for Adult Waiver to Criminal Court	Age of Criminal Responsibility	Age of Majority	Age of Eligibility for Marriage	Age at and Above Which Child Must Consent to Adoption
NEW JERSEY	17	16	16	18	18; with PC if under 18	*
NEW MEXICO	17	15 (fel.)	15[10]	18	18; with PC-16; PC & CC-under 16	10, WBC
NEW YORK	15	No provision	16[19]	18	18; with PC-16-m, 14-f	14, WBC
NORTH CAROLINA	15	14 (fel.)	14[10]	18	18; with PC-16	12
NORTH DAKOTA	17	16	16[20]	18	18; with PC-16; PC & CC-under 16	10, WBC
OHIO	17	15	15[20]	18	18; with PC-under 18	12, WBC
OKLAHOMA	17	No age[22]	14[21]	18	18; with PC-under 18	12
OREGON	17	16	14[23]	18 or marriage	18; with PC-under 18	14
PENNSYLVANIA	17	14	14[20]	21	18; with PC-under 18	12
RHODE ISLAND	17	16 (fel.)	16[20]	21	21; with PC-18-m, 16-f	14

STATE	Maximum Age of Juv. Ct., Juris., Non-Traffic Crimes	Minimum Age for Adult Waiver to Criminal Court	Age of Criminal Responsibility	Age of Majority	Age of Eligibility for Marriage	Age at and Above Which Child Must Consent to Adoption
SOUTH CAROLINA	15	No provision	15[24]	21	18; with PC-16-m, 14-f	No provision
SOUTH DAKOTA	17	10[25]	10[25]	18	18; with PC-16	12
TENNESSEE	17	16/ 15 (serious fel.)	16[20]/ 15	18	18; with PC-16	14
TEXAS	16	15	15[26]/ 10	18	18; with PC-16	12, WBC
UTAH	17	14 (fel.)	14[27]	18 or marriage	18; with PC-under 18	12
VERMONT	15	No provision	15[28]	18	18; with PC-16; with PC & CC-under 16	**
VIRGINIA	17	15 (fel.)	15[10]	18	18; with PC-16	14, WBC
WASHINGTON	17	No[29] age	12[29]	18	18; with PC-17	14
WEST VIRGINIA	17	No provision	***	18	18; with PC-16-f	12, WBC
WISCONSIN	17	16	16[21]	18	18; with PC-16	14
WYOMING	17	Any age	7[30]	19	19; with PC-18-m, 16-f; PC & CC-m-under 18, f under 16	14

NOTES TO APPENDIX

1/ To 17 Jan. 1, 1978.

2/ Statutes silent; common law presumed to apply.

3/ Adult criminal court has exclusive original jurisdiction, and usually "suspends" criminal prosecution and remands to juvenile court. May refuse suspension, regardless of age; in light of §13-135 (modeled after Cal.Pen.Code §26) and State v. Taylor, 512 P.2d 590 (1973), 7 and above could be held criminally liable.

4/ All kids waivable, but "No infant under 12 shall be found guilty of any crime" §41-112.

5/ Statute says "child" (defined as one under 16) not to be prosecuted in criminal court. No other mention. Age is 14 if child meets waiver requirements.

6/ Any juvenile, if capital offense or punishable by life.

7/ Common-law presumptions inapplicable. State v. D.H., 340 S.2d 1163 (1976).

8/ Common-law inapplicable; commentary to §704-418.

9/ Statute silent; gives age for waiver and case law holds juvenile adjudication not criminal conviction.

10/ Statute silent; gives age for waiver only.

11/ Statute specifically states age of criminal responsibility to be 18, save when child is waived. Presumably, common limitation (age 7) inapplicable.

12/ Criminal court has original jurisdiction over minors 14 and over charged with offenses punishable by death or life imprisonment.

13/ Can waive minor under 14 if offense punishable by death or life imprisonment.

14/ Criminal responsibility statute amended specifically to conform with waiver age.

15/ 1976 change lets 18-21-year-olds contract re personal property

16/ No waiver; 16 year olds who commit listed violent offenses go automatically to criminal court.

NOTES TO APPENDIX (cont.)

17/ Misdemeanors only; any age for felony, but presumably limited by common-law age of incapacity (7).

18/ Common law limit of 7 would apply.

19/ Statute provides infancy defense below age where juvenile court loses jurisdiction.

20/ Statute silent; gives age for waiver and provides that no child shall be criminally prosecuted unless waiver.

21/ Statute modeled after California Penal Code §26 -- applicable to juvenile court proceedings per case similar to Gladys R.

22/ Limited by codified common law age of incapacity (7).

23/ Criminal responsibility statute on its face applies only to juvenile remanded and tried as adult. Juvenile court proceeding not trial by statute. Age of 14 probably meaningless, as waiver age is 16.

24/ No criminal responsibility statute, no waiver. Common law would presumably apply, providing infancy defense below age 7 -- although by statute, not criminal proceeding.

25/ No criminal responsibility statute; delinquent child defined as "between 10 - 17" -- only "delinquent child" can be transferred for criminal prosecution.

26/ According to commentary, statute purporting to deal with criminal responsibility of infants not meant to provide defense of infancy (per common law), but only to emphasize that juvenile court proceedings not criminal, and child can only be criminally prosecuted after waiver, which requires age 15. However, jurisdictionally, juvenile court has no jurisdiction under age 10.

27/ Statute modelled after California Penal Code §26.

28/ No waiver, statute provides that juvenile court proceedings non-criminal.

NOTES TO APPENDIX (cont.)

29/ Criminal responsibility statute holds children under 8 incapable of criminal responsibility. Presumption of incapacity between 8-12. Presumably, this would apply to waiver proceedings.

30/ Common-law minimum age; statute silent re: criminal responsibility; no statutory provision to the effect that juvenile proceedings not criminal.

* When prospective adoptee is 10 or more, adoption agency must report to court on "understanding and wishes" of child. Not binding and court may waive this requirement.

** Consent of minor only required if he/she is married.

*** Would be 17; no waiver, and statute states juvenile proceedings non-criminal. Exception: capital offense, wherein original jurisdiction is in criminal court. Presumably, infants below 7 would not be liable because of common law -- statutes silent.

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ALABAMA CODE: Tit. 1, §3; tit. 13A, §5-101, et seq., tit. 34, §4; tit. 27, §13, §26, et seq.

ALASKA CODE: §§20.15.040, 47.10.060, 47.10, 25.05.181, 25.05.171, 25.20.010.

ARIZONA REVISED STAT. ANN.: §§8-202A, 8-106, 25-102; ARIZ. CONST. Art. 6, §15; State v. Taylor, 109 Ariz. 481, 512 P.2d 590 (1973); McBeth v. Rose, 111 Ariz. 399, 531 P.2d 156 (1975).

ARK. STAT. ANN.: §§41-112, 45-403, 45-420, 55-102, 56-107, 57-103; Dove v. State, 37 Ark. 261.

CAL. W & I CODE: §§602, 707; CAL. CIVIL CODE: §§25, 225, 4101; CAL. PENAL CODE §26; In re Gladys R., 1 C.3d 855 (1970); In re Michael B., 44 C.A. 3d 443 (1975).

COLO REV. STATS.: §§19-1-103, 19-1-104, 18-1-801, 19-4-107, 14-2-106, 14-2-108; People ex rel. Terrell v. District Court, 164 Colo. 437, 435 P.2d 763 (1967).

CONN. GEN. STAT. ANN.: §§17-53,17-60a, 17-60b, 17-72, 45-61; 46-5g, 46-5f, 1-1d, cf. State v. Elbert, 162 A. 769, 115 Conn. 589 (1932).

DEL. CODE ANN.: Tit. 10, §§901, 938, 931; tit. 13, §§907, 123, 901; tit. 1 §701.

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BURNS' IND. STAT. ANN.: §§31-1-1-4, 31-3-1-6, 32-1-13-2, 31-3-1-6, 31-5-7-4.1; Adams v. State, 244 Ind. 460, 193 N.E. 2d 362 (1963).

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KY. REV. STAT.: §208.020, 208.170, 199.500, 405.010, 405.020.

LA. REV. STAT.: §§14:13, 13:1571.1, 13:1569, 13:1570; LA. CIVIL CODE Art. 37.

MAINE REV. STAT. ANN.: tit. 15 §§2552, 2611; tit. 19 §§4, 62, 532; tit. 17-A §53.

ANN. CODE MD.: "Courts and Judicial Process" [special title] §§3-801, 3-808, 3-809, 3-816; Code proper, Art. 1, §24; Art. 62 §9; Art. 16 §74.

MASS. GEN. LAWS ANN.: Ch. 119 §§52, 61; ch. 4 §7; ch. 210 §2; ch. 207 §§7, 9.

MICH. COMP. LAWS ANN.: §§712A.1, 712A.2, 712A.4, 710.43, 10.22, 551.103.

MINN. STATS. ANN.: §§260.111, 260.015, 260.125, 259.24; cf. State v. Olson, 156 M. 181, 194 N.W. 942 (1923).

MISS. CODE ANN.: §§43-21-5, 43-21-7, 43-21-31, 43-21-35, 93-1-5, 93-17-5, 93-19-1, 93-19-13.

VERNON'S ANN. MO. STATS.: §§211.021, 211.071, 211.011, 453.030, 475.010, 475.055; State v. Harold, 364 Mo. 1052, 271 S.W. 2d 527 (1954), appeal transferred 281 S.W. 2d 605.

REV. CODES MONT.: §§10-602, 94-201, 48-306, 48-308, 61-207, 64-101.

REV. STATS. NEB.: §§43-202, 43-202.01, 42-105, 43-104, 38-101.

NEV. REV. STATS.: §§194.010, 62.010, 129.010, 62.080, 127.020.

N.H. REV. STATS. ANN.: §§170-B:5, 457:5, 457:4, 21:44, 21-B:1, 169:2, 169:21.

N.J. STATS. ANN.: §§9:17B-3, 2A:4-43, 2A:85-4.

N.M. STATS. ANN.: §§13-14-3, 13-13-1, 13-14-28, 40A-1-3, 22-2-25.

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ORE. REV. STATS.: §§106.060, 109.328, 109.510, 109.520, 161.380, 419.533, 419.543, 419.476.

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S.C. CODE OF LAWS: §§20-24, 20-24.1, 10-2587.2, et seq., 15-1103.

S.D. CODE LAWS: §§26-8-1, 26-11-4, 26-8-22.7, 26-8-7, 26-1-1, 25-6-5.

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VERNON'S ANN. TEX. STATS., PROBATE CODE, §3; VERNON'S TEX. CODES ANN., PENAL CODE, §8.07; VERNON'S TEX. CODES ANN., FAMILY CODE, §§1.51, 16.05, 51.02, 54.02.

UTAH CODE ANN.: §§15-2-1, 76-1-41, 78-3a-2, 78-3a-25, 78-30-6, 30-1-9.

VT. STAT. ANN.: tit. 1 §173; tit. 15 §435; tit. 18 §5142; tit. 33 §§632, 662.

VA. CODE ANN.: §§1-13.42; 16.1-228, -241, -269; 20-45-1, -48; 63.1-225.

REV. CODE WASH. ANN. §§13.04.010, 13.04.120, 9A.04.050, 26.04.010, 26.04.210, 26.28.010, 26.32.030.

W. VA. CODE: §§48-4-1, 48-1-1, 48-1-8, 2-2-10, 49-1-4, 49-5-3, 49-7-3

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Supreme Court, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 75 - 1690

T. M. "JIM" PARHAM, ET AL.,

Appellants,

— v. —

J. L. AND J. R., ET AL.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

BRIEF FOR THE URBAN LAW INSTITUTE AS AMICUS CURIAE

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September 1977

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IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1977

No. 75 - 1690

T.M. "JIM" PARHAM, et al.,

Appellants,

vs.

J.L. and J.R., et al.,

Appellees.

BRIEF FOR THE URBAN LAW INSTITUTE AS AMICUS CURIAE

MANNER OF FILING

This brief amicus curiae is filed by the Urban Law Institute with the written consent of the parties, as provided for in Rule 42 of the Rules of this Court.

INTEREST OF THE AMICUS

The Urban Law Institute was established in 1968 as a legal research and development project funded by the National Legal Services Corporation. The primary purpose of the Institute is to assist in providing more and improved legal services for the poor. The Institute believes that every person, rich or poor, is entitled to equal justice under law. The Institute is concerned with a wide range of legal problems which confront the unrepresented poor of this nation. In its capacity as legal counsel for the poor, the Institute utilizes the legal system in an attempt to solve a variety of problems through effective advocacy in a manner once reserved only for the economically secure of the United States.

Mental Health is a field having problems of particular concern to the Urban Law Institute. The Institute is presently involved in major litigation affecting the rights of the mentally disabled residents of Forest Haven, an institution operated by the District of Columbia. The disposition of the present case will have significant impact on Evans v. Washington no. 76-0293 (D.D.C.) and a wide range of other cases in which the Institute is currently involved. This amicus brief will address only the question of state action the Court directed the parties to brief in its May 31, 1977 order noting probable jurisdiction.

QUESTION PRESENTED

Whether, where the parents of a minor voluntarily place the minor in a state institution, there is sufficient "state action", including subsequent action by the state institution, to implicate the Due Process Clause of the Fourteenth Amendment?

ARGUMENT

I. THE SUMMARY COMMITMENT OF APPELLEES TO STATE MENTAL INSTITUTIONS AS AUTHORIZED BY GEORGIA CODE SECTION 88-503.1 OCCURRED UNDER COLOR OF STATE LAW THEREBY IMPLICATING THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT.

A. State Action Is Present Where Significant Governmental Interests Are Exercised By The Delegation Of State Power To Private Persons Who Along With The State Act With The Force Of Law.

The Fourteenth Amendment is designed to protect individuals from state action, whether overt or covert, which deprives them of fundamental rights. Moose Lodge No. 107 v. Irvis, 407 U.S. 163, 173 (1972). The manner in which the state may infuse its policies and interests into objectionable conduct may take differing forms:

> "a state may act through different agencies, either by its legislative, its executive or its judicial authorities; and the prohibitions of the [Fourteenth] Amendment extend to all action of the State. . . , whether it be action by one of these agencies or by another." Ex Parte Virginia, 100 U.S. 339, 347 (1879).

By focusing on the state's role in such conduct, this Court has developed an expansive body of state action law subjecting so-called private conduct to constitutional scrutiny.1/

1/ See Thompson, Piercing the Veil of State Action, 1977 WISCONSIN L. REV. 1. See also, Nerken, A New Deal for the Protection of Fourteenth Amendment Rights: Challenging the Doctrinal Bases of the "Civil Rights" Cases and State Action,

This expansive trend of decisions has been marked by the Court's reluctance to articulate a single state action formula. Rather, by a process of "sifting facts and weighing circumstances," the Court has sought to evaluate significant state policies and interests that intrude into private relationships and are reflected in particular conduct. Burton v. Wilmington Parking Authority, 365 U.S. 715, 722 (1961); Reitman v. Mulkey, 387 U.S. 369 (1967).

The Court has been presented with the state action issue in a variety of factual situations. As a result, the Court has approached this issue in an equally varied manner. We submit, however, that these seemingly diverse approaches reflect differing emphases of a singular unifying theme:

> State action is present where significant governmental interests are exercised by the delegation of state power to private persons who along with the state act with the force of law.

This theme is apparent in each of the following approaches employed by the Court:

1. Private parties who are clothed with state authority and act with the force of law. United States v. Williams, 341 U.S. 97 (1950); United States v. Price, 383 U.S. 787 (1965); United States v. Guest, 383 U.S. 745 (1965); Griffin v. Maryland, 378 U.S. 130 (1964).

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12 HARV. CIVIL RIGHTS - CIVIL LIB. L. REV. 297 (1977).

2. Private parties whose conduct is subject to pervasive state regulation. Public Utilities Comm'n v. Pollak, 343 U.S. 451 (1952); Burton v. Wilmington Parking Authority, supra; Moose Lodge No. 107 v. Irvis supra; Smith v. Allwright, 321 U.S. 649 (1944); Terry v. Adams, 345 U.S. 461 (1953); Nixon v. Condon, 286 U.S. 73 (1932); Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974).

3. Private action encouraged or compelled by state law and reflecting current state policy. Reitman v. Mulkey supra; Adickes v. S. H. Kress & Company, 398 U.S. 144 (1970); Moose Lodge No. 107 v. Irvis, supra; Peterson v. City of Greenville, 373 U.S. 244 (1963); Lombard v. State of Louisiana, 373 U.S. 367 (1963); Robinson v. Florida, 378 U.S. 153 (1964); Nixon v. Condon, supra; McCabe v. Atchison, Topeka & Santa Fe R. Company, 235 U.S. 151 (1914); Evans v. Abney, 396 U.S. 435 (1970); Shelley v. Kraemer, 334 U.S. 1 (1948).

4. Private action taken with reliance on state law, custom or usage. Adickes v. Kress, supra; Evans v. Abney, supra.

5. Private action involving the performance of traditional public functions delegated to private individuals. Smith v. Allwright, Terry v. Adams, supra; Nixon v. Condon, supra; Evans v. Newton, 382 U.S. 296 (1966); Marsh v. Alabama, 326 U.S. 502 (1946).

6. Governmental action placing monopoly power in the hands of private entities to promote state policies. Railway Employees' Dept. v. Hanson, 351 U.S. 225 (1956); International Ass'n of Machinists v. Street, 367 U.S. 740 (1961); Lanthrop v. Donahue, 367 U.S. 830 (1961);2/ cf. Steele v. Louisville & N. Ry., 323 U.S. 192 (1944); American Communications Ass'n v. Douds, 339 U.S. 382 (1950).

In essence, the Court has evaluated the pervasiveness of state intrusion into the quasi-private relationship and assessed the state interests reflected in the objectionable conduct. The Court's characterization of the state action issue in the foregoing cases demonstrates an attempt to identify particular state interests in variant circumstances. Thus, the linchpin of the Court's analysis, although expressed in differing forms, contains a principled view of state action. Where this principle is operative, state action exists.

A closer review of the major decisions finding particular private conduct subject to the constraints of the Fourteenth Amendment illustrates the applicability of this principle.

The existence of a comprehensive state election code reflecting a systematic promotion of the state's discriminatory voting policy was sufficient to support a finding of state action in Nixon v. Condon, Smith v. Allwright, and Terry v. Adams. In each case, the statute guaranteed that a private political party could determine the qualifications of its members and thereby prohibit Negroes from participating in state primaries or the party's electoral process. Thus, the party was able to employ the state election code to enforce the state's "whites only" voting policy.

Describing the state's intrusion into the structure of private political parties, the Court observed:

2/ See Lavoie v. Bigwood, 457 F.2d 713 (1st Cir. 1972), for the "monopoly" characterization of these Supreme Court cases.

". . .the statute here in controversy has attempted to confide authority to determine of its [Executive Committee's] own motion the requisites of party membership and in so doing to speak for the party as a whole." Nixon v. Condon, 286 U.S. at 85;

". . .the state [through its election code] endorses, adopts and enforces the discrimination against Negroes. . ." Smith v. Allwright, 321 U.S. at 664; and

"It is immaterial that the state does not control that part of this elective process which it leaves for the Jaybirds to manage. The Jaybird primary has become an integral part, indeed the only effective part, of the elective process that determines who shall rule and govern in the county." Terry v. Adams, 345 U.S. at 469.3/

By legislating the relationship between a private political party and the electorate in such a way as

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3/ In Evans v. Newton, 382 U.S. 296 (1966) the Court found sufficient "state action" where a city, pursuant to a privately created trust, managed a park which had become a public facility. Mr. Justice Douglas enunciated the Court's rationale:

> ". . .when private individuals or groups are endowed by the State with powers or functions governmental in nature, they become agencies or instrumentalities of the State and subject to its constitutional limitations." 382 U.S. at 299.

to guarantee the party's unfettered discretion in determining the qualification of its members, the state: (1) governed the structure of private political parties, (2) delegated specific state functions to a private organization, and (3) enabled the private party to act with the force of law in promoting the state's discriminatory voting policy. Thus, all of the elements of the general state action principle coalesce in these cases.

State action has also been found in a series of cases concerning the regulation of private businesses affairs. In Peterson v. City of Greenville, 373 U.S. 244 (1963) and Lombard v. State of Louisiana, 373 U.S. 267 (1963), the Court dealt with municipal regulatory schemes 4/ governing the relationship between restaurant proprietors and their customers. The delineation of the manner in which restaurant service was to be provided manifested a distinct state policy favoring segregated eating facilities. As a direct result, restauranteurs structured their business operations so as to refuse service to Negroes. Such intensive control and impact established the prerequisites for state action.

The decision in Robinson v. Florida, 378 U.S. 153 (1964) further demonstrates the determinative impact of legislative policies on a particular private business relationship. In Robinson the municipal scheme only provided for segregated rest room facilities in restaurants. Relying on this enactment,

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4/ In Peterson, supra, a city ordinance established a detailed scheme for restaurant segregation. In Lombard, supra, the statements of public officials were held to be the legal equivalent of an ordinance determining the relationship between a restaurateur and his customers. 373 U.S. at 273.

restaurateurs enforced state policy by providing separate eating facilities for each race. By fashioning his business conduct in accord with the discriminatory policy, the restaurateur acted with the force of law.

In Reitman v. Mulkey, 387 U.S. 369 (1967), the United States Supreme Court reviewed a clause in the California Constitution which prohibited restrictions on an individual's right to sell or lease real property to whomever he chose. The Court affirmed decisions of the California Supreme Court5/ finding that the enactment of Proposition 14 6/ constituted significant state involvement in private real estate transactions.

In reaching its conclusion, this Court focused on two crucial points: (1) the state had adopted, as current policy, the right of private parties to discriminate in the sale or rental of real estate; (2) that private parties could now invoke state law to accomplish discrimination and were thereby encouraged to do so.

Assessing the ultimate effect or impact of Proposition 14, the Court concluded:

5/ Mulkey v. Reitman, 64 Cal. 2d 529, 413 P. 2d 825, 50 Cal. Rptr. 881 (1966); Prendergast v. Snyder, 64 Cal. 2d 877, 413 P. 2d 847, 50 Cal. Rptr. 903 (1966).

6/ Proposition 14, adopted as Article I, § 26 of the California Constitution provided that:

> "Neither the State nor any subdivision or agency thereof shall deny, limit or abridge, directly or indirectly, the right of any person, who is willing or desires to sell, lease or rent any part or all of his real property, to decline to sell, lease or rent

"The right to discriminate, including the right to discriminate on racial grounds, was now embodied in the State's basic charter, immune from legislative, executive, or judicial regulation at any level of the state government. Those practicing racial discrimination need no longer rely on their personal choice. They could now invoke express constitutional authority, free from censure or interference of any kind from official sources." 387 U.S. at 376, 377.

Thus, the state's intrusion into the private arena so permeated the transaction as to constitute state action.7/

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such property to such person or persons as he, in his absolute discretion chooses."

7/ See also McCabe v. Atchison, Topeka & Santa Fe R. Co., 235 U.S. 151 (1914), where a state statutory scheme governed the relationship between common carriers and their customers, including the physical construction of railroad cars, in such a way that it injected a state racial policy into the operation of the railroad; and, Adickes v. S.H. Kress & Co., 398 U.S. 144, 173-74 (1970), where the Court held that private parties who act with knowledge of and pursuant to state enforced "custom and usage" (42 U.S.C. §1983) act "under color of" law. As Mr. Justice Brennan stated, concurring in part and dissenting in part, "when private action conforms with state policy, it becomes a manifestation of that policy and is thereby drawn within the ambit of state action." 398 U.S. at 203.

The Court's decision in Moose Lodge No. 107 v. Irvis, 407 U.S. 163 (1972) is fully consistent with the state action principle enunciated herein. In Moose Lodge, the Court held that the mere existence of a liquor license did not involve the state in a private club's discriminatory guest or membership policies. The licensing provisions did not establish a regulated pattern of private conduct in the sale of liquor. Unlike the cases previously discussed, the legislative enactments in Moose Lodge in no way governed the discriminatory relationship between the club and the persons to whom it served liquor. Nor did the state in any way delegate its authority to the club in order to accomplish discrimination. The Court noted that a liquor license did not "in any way foster or encourage racial discrimination." 407 U.S. at 176, 177. Thus, the possession of a liquor license had no impact on the private conduct complained of, and could not serve as a basis for a finding of state action.8/

Although no state action was found on the facts presented in Moose Lodge, the Court did reaffirm the basic principle guiding its approach to the state action question. Specifically, the Court indicated that had the regulatory scheme governed a liquor licensee's course of dealing with minorities or promoted a state policy favoring discrimination, then state action would have been present:

8/ Likewise in Evans v. Abney, 396 U.S. 435 (1970) the statutes authorizing the formation of wills did not clearly promote an identifiable state interest favoring discrimination, nor was there any evidence that the testator was persuaded or induced by the statute to discriminate.

"There is no suggestion in this record that the Pennsylvania statutes and regulations governing the sale of liquor are intended either overtly or covertly to encourage discrimination." 407 U.S. at 175, 176.

This is the so-called "nexus" test. In other words, in order for there to be significant state involvement to constitute state action one must not only demonstrate the state's presence but that the state encourages or fosters the action complained of. We will now demonstrate the significant involvement of the State of Georgia in the commitment process of juveniles in state mental institutions.

B. The Application Of The Principle Of Delegating State Power To Private Persons Requires A Finding Of State Action in The Instant Case.

The foregoing analysis reveals that where significant state interests are implemented through the delegation of state power to private individuals, the resultant conduct has the force of law and is thus subject to constitutional scrutiny. An examination of Georgia's statutory scheme regarding the "voluntary" and summary commitment of juveniles by their parents to state mental institutions compels but one inescapable conclusion: the state is significantly involved in the loss of appellees' liberty and denial of procedural due process rights as to implicate the fourteenth amendment.

It is well established that state action may emenate from conduct of administrative and regulatory agencies as well as from judicial and legislative action. Moose Lodge v. Irvis, 407 U.S. 163 (1972). This Court requires a careful sifting of facts and weighing of circumstances to properly determine the role of the state. We will demonstrate significant state involvement by Georgia in the

summary commitment of juveniles upon application by parents under GA. CODE ANN. Section 88-503.1. The state's active and indisputable role in the institutionalization process challenged here will support our contention that state action is evident from the aggregate facts of this case.

The state of Georgia has a significant interest in the mental health of its citizens, both adults and juveniles. It operates a comprehensive statewide program of treatment services for mentally ill children and adults at great public expense. Under a comprehensive statutory scheme,9/ the Department of Human Resources operates eight regional in-patient hospital facilities. Out-patient services are rendered at approximately fifty community health centers. In fiscal year 1976, the state of Georgia spent $149,791,851 to provide mental health care for its citizens.10/

Pursuant to this statutory scheme, state mental health officials act in concert with parents to unconstitutionally deprive juveniles of their liberty. The state is the principal actor here. It has statutorily created a relationship between parent, child, and state official in the mental health commitment process. But for the direct involvement of the state, the unconstitutional acts complained of here could not have been accomplished. Moose Lodge v. Irvis supra at 176.

The operation of Section 88-503.1 authorizes the summary commitment of juveniles under the guise of

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9/ GA. CODE ANN. ch 88-5; 1969 Ga. Laws 505.

10/ State of Georgia Budget Report Fiscal Year 1977, Vol. I.

a "voluntary" admission procedure. Acting pursuant to power delegated by the statute, a parent may apply to institutionalize the juvenile at any time. This same statute authorizes state mental health officials to receive juveniles for observation and diagnosis upon application. Observation and diagnosis usually require about one week. The minimum stay, prescribed by law, is five days. There is no established maximum period of confinement. Throughout this critical period of evaluation the juvenile is under the total dominion and control of state mental health officials. He is confined to a regional hospital behind locked doors. Newly received juveniles are not segregated from those already committed. No less restrictive form of treatment than total commitment is provided. Georgia mental health officials, not parents, conduct the observation and diagnosis period required by the contested statute. It is the state that makes the sole determination where, and under what conditions, the juvenile will be committed. The state establishes commitment standards, administers diagnostic tests, and evaluates the performance of the juvenile. If the juvenile shows signs of mental illness, the state makes the ultimate decision, independent of the parents, to institutionalize the child. The state also designates the appropriate time and conditions of discharge.

Finally, the state may confine an individual committed under Section 88-503.1 until he is recovered or until it is determined that commitment is no longer necessary or desirable. Yet the state is powerless to release the juvenile in the absence of parents who are ready, willing, and able to take the child back into their home.

These provisions more than adequately demonstrate the active and direct role of the state in the chal-

lenged process. The contested statute unconstitutionally permits parents and state mental health officials to involuntarily commit juveniles to state mental hospitals under the guise of a "voluntary" procedure. In practice juveniles, committed under Section 88-503.1, have a right to leave the institution only when the state decides that release is appropriate.

Ultimately, the question in any state-action case is not whether a single fact or relationship presents a sufficient degree of state involvement, but rather whether the aggregate of all relevant factors compels a finding of state responsibility. Burton v. Wilmington Park Authority supra at 722-726. The aggregate facts and circumstances surrounding appellees commitment here compel a finding of state responsiblity in the instant case. The unconstitutional confinement is the direct result of the state's conduct. Pursuant to statutory authority, state mental health officials received appellees for observation and diagnosis and caused the resultant loss of liberty. The Constitution proscribes any state conduct which deprives a citizen of liberty without due process of law. The state of Georgia is responsible for the enactment and administration of a statutory scheme which permits:

(1) juveniles to be committed without a hearing
(2) juveniles to be institutionalized without initial or periodic considerations of placement in the least drastic environment necessary for treatment;
(3) juveniles, once confined, to be denied a hearing for the determination of an appropriate required time for discharge.

The state of Georgia is singularily responsible for the total absence of due process safeguards.

In United States v. Guest, 383 U.S. 745 (1966), this Court noted the fourteenth amendment protects individuals against state action. The involvement of the state need not be direct. It may be only one of several cooperative forces leading to the constitutional violation. Georgia cannot justly avoid responsibility for its direct involvement here. The legislature has enacted a comprehensive statute which, in concept and practice, vests in superintendents of state mental health hospitals unbridled power to commit so called emotionally disturbed children to state mental hospitals at least until their eighteenth birthday. The facts and circumstances that surround the adoption and operation of the challenged statute compel a finding of state responsiblity here. This Court must insist on Georgia's strict adherence to the due process requirements of the fourteenth amendment.

CONCLUSION

For the above-stated reasons the decision below should be affirmed.

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Supreme Court, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM—1975

No. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

On Appeal from the Judgment of the United States District Court for the Middle District of Georgia

BRIEF AND APPENDIX OF *AMICUS CURIAE*, DEPARTMENT OF THE PUBLIC ADVOCATE, DIVISION OF MENTAL HEALTH ADVOCACY, STATE OF NEW JERSEY

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

vs.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

On Appeal from the Judgment of the United States District Court for the Middle District of Georgia

BRIEF OF *AMICUS CURIAE*, DEPARTMENT OF THE PUBLIC ADVOCATE, DIVISION OF MENTAL HEALTH ADVOCACY, STATE OF NEW JERSEY

Summary of Argument

The Department of the Public Advocate, Division of Mental Health Advocacy, a statutory agency, has, since September 8, 1975, provided legal representation to individuals facing civil commitment proceedings, including juveniles, pursuant to *New Jersey Court Rule* 4:74-7, under a format comporting with procedural due process (Point I.A, B). *Amicus'* experience in providing such representation effectively rebuts those arguments raised by appellants alleging exacerbation of familial situations and traumatization of the child (Point I.C).

Similarly, relevant case law, scholarly literature and available empirical evidence further rebut such arguments by appellants (Point II).

Interest of *Amicus Curiae*

This case presents the significant issue of what process is due to juveniles facing civil commitment proceedings. *Amicus curiae,* Department of the Public Advocate, Division of Mental Health Advocacy, is an administrative agency of the State of New Jersey statutorily authorized to represent—both individually and on a class action basis—persons subject to such proceedings, on any issue pertinent to the commitment to, release from, or confinement in mental institutions throughout the State.[1] In this capac-

[1] For a discussion of the nature and scope of functions of the Division of Mental Health Advocacy in particular, see Perlin and Siggers, "The Role of the Lawyer in Mental Health Advocacy," 4 *Bull. Am. Acad. Psych. & L.* 205 (1976); Van Ness and Perlin,

(Footnote continued on following page)

ity, the Division of Mental Health Advocacy has undertaken to represent both adults and juveniles in commitment matters through procedures which satisfy the mandate of the District Court in this matter. *J.L.* v. *Parham,* 412 F. Supp. 141, 143 (M.D. Ga. 1976).

As will be discussed further, *infra* (see Point I.A.), the Division of Mental Health Advocacy has established two field offices[2] to provide representation, on an individualized basis, to residents of three counties[3] at commitment pro-

(Footnote continued from preceding page)

"The Mental Health Advocate: The New Jersey Experience," in Kopolow and Bloom, eds., *Mental Health Advocacy: An Emerging Force in Consumers' Rights* (N.I.M.H. ed. 1977) (in press); Note, "The Office of Public Counsel: Institutionalizing Public Representation in State Government," 64 *Geo. L.J.* 895, 900-902 (1976). See also, for discussions of the Department of the Public Advocate in general, Penn, "Advocate From Within," 12 *Trial Mag.* 20 (February 1976); Heffner, "Legislative Oversight: An Analysis of L.1974, Chapter 27, Department of the Public Advocate Act," *Seton Hall Leg. J.*, Vol. 1, No. 2 (Summer 1976), at 75; Note, "The Department of the Public Advocate—Public Interest Representation and Administrative Oversight," 30 *Rutgers L. Rev.* 386 (1977); Herr, *Advocacy Under the Developmental Disabilities Act* (Temple U. Publ. 1976).

For a specific discussion of the role of the Division in representing juveniles in the civil commitment process, see, Note, "Due Process Limitations on Parental Rights to Commit Children to Mental Institutions," 48 *U. Colo. L. Rev.* 235, 258 (1977).

[2] As of September 6, 1977, it is expected that these services will be expanded to another three counties as well. See footnote 4, *infra.*

[3] See footnote 4, *infra.*

ceedings, periodic review hearings, and individual matters concerning conditions of confinement or release.[4] Through this brief, the Division of Mental Health Advocacy hopes to apprise this Court of its experience in providing legal representation to juveniles subject to the civil commitment process.

The Division of Mental Health Advocacy files this brief as *amicus curiae* with the consent of all parties to this appeal. See letter from Joseph J. Levin, Jr., Counsel of Record for Appellees, and R. Douglas Lackey, Assistant Attorney General, State of Georgia, to Mr. Michael Rodak, Clerk, U. S. Supreme Court, set forth in the Appendix at 1a.

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[4] As noted *infra*, the original decision to establish two field offices was primarily premised on the availability of financial allocations. The entire Division operated on an annual budget of $550,698 in fiscal 1977. The three counties covered by the two field offices combined accounted for approximately 34% of the involuntary commitment proceedings initiated statewide in calendar year 1976 (total number of cases docketed January-December 1976: 3551; of those, 920 were from Essex County, 281 were from Mercer County, and 19 were from Hunterdon County).

The Division's appropriation has been increased to $789,795 for fiscal 1978, with $200,000 of the increase specifically allocated to enable the Division to establish another field office in Camden County to provide similar services to persons residing in Camden, Gloucester and Salem Counties. As 188 involuntary civil commitment cases were docketed from these three counties in calendar 1976 (131 from Camden, 34 from Gloucester and 23 from Salem), the Division will thus be assuming representation of 39% of all such proceedings beginning as of September 6, 1977.

It should also be noted that a bill currently before the New Jersey legislature, S.1674, would expand the Division statewide and mandate that it represent *all* persons subject to the civil commitment process (in addition to appreciably expanding its other representation and advocacy jurisdictions).

ARGUMENT

POINT I

I. The New Jersey Department of the Public Advocate, Division of Mental Health Advocacy has, since September 8, 1975, provided juveniles facing civil commitment proceedings representation in a manner similar to the procedural format mandated by the Court below.

A. The Division of Mental Health Advocacy is a statutory agency of the State of New Jersey charged with the responsibility to provide legal representation to individuals subject to involuntary civil commitment proceedings.

The Division of Mental Health Advocacy, a State agency within the New Jersey Department of the Public Advocate, has express statutory authority to

> provide such legal representation and medical consultation as the director deems appropriate for any indigent mental hospital admittee in any proceeding concerning the admittee's admission to, retention in, or release from confinement in such a hospital, institution or facility. N.J.S.A. 52:27E-24.

Pursuant to this statutory grant, and consonant with the available fiscal appropriations, the Division of Mental Health Advocacy (hereinafter "the Division") has established two field offices to provide legal counsel to individual "indigent mental hospital admitees."[5] These offices are

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[5] The Division also maintains a class action office, located in Trenton, with statewide jurisdiction and the statutory authority to

(Footnote continued on following page)

located in Newark and Trenton.[6] The former, designated the Essex Regional Office, provides representation at commitment hearings, periodic review hearings,[7] *habeas corpus* hearings, and individual cases involving conditions of treatment or confinement; the population served by this Office is comprised of all Essex County residents who are or may become institutionalized anywhere in the State, as well as the entire patient population at the Essex County Psychiatric Hospital in Cedar Grove. The Trenton office, denominated the Mercer Regional Office, provides the same four types of services to all residents of Mercer County facing institutionalization, including those residing at Trenton Psychiatric Hospital.[8]

(Footnote continued from preceding page)

> represent the interests of indigent mental hospital admittees in such disputes and litigation, as will, in the discretion of the Director . . . best advance the interests of indigent mental hospital admittees as a class on an issue of general application to them. . . . N.J.S.A. 52:27E-25.

For a discussion of the results of some of these class actions, see Perlin and Siggers, 4 *Bull. Am. Acad. Psych. & L., supra,* at 207.

[6] As indicated at footnote 4, *supra,* the Division is in the process of establishing a similar office in Camden County.

[7] On November 12, 1974, Chief Justice Richard J. Hughes of the New Jersey Supreme Court issued Memorandum #4-74 to all assignment judges, trial court administrators and county clerks, establishing among other procedures, a schedule of periodic reviews of "all persons who are now, or may hereafter become, involuntarily committed" in the State. The memorandum also mandated docketing and scheduling procedures for final commitment hearings which essentially presaged the current N.J. Ct. R. 4:74-7. The full text of the memorandum is set forth in the Appendix at 3a.

[8] The Mercer Regional Office has also assumed responsibility for providing representation to clients residing in Hunterdon County, a smaller area adjacent to Mercer County.

The regional offices are staffed by attorneys (three in Trenton, five in Newark) and "field representatives" (three in Trenton, five in Newark). This latter term denotes non-lawyer staff personnel who are, by virtue of background training and prior work experience, mental health professionals.[9] Although conceived of, by statute, as "law

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[9] The supervisor of all the field representatives in the Division, who works out of the Trenton office, holds a Doctorate in psychology and had more than five years of prior work experience in related mental health fields. In the Trenton office, the supervising field representative holds a Doctorate in Social Psychology, and has seven years of experience in mental health related fields prior to coming to the Division; another field representative holds a Masters degree in Social Work and a year of prior experience as a social worker; the third field representative holds an Associate of Arts degree and has had two years prior experience in mental health related areas.

The supervising field representative in the Newark office holds a Master of Arts degree and has completed two years of study toward his Doctorate in psychology. He worked for three years as a clinical psychologist prior to coming to the Division. Another field representative holds a Masters degree in Social Work and has had more than two years prior experience in mental health related areas. Two others hold Bachelor of Arts degrees and together have had more than four years of related work experience. One position is currently vacant.

The supervising field representative in the planned Camden office holds a Doctorate in Clinical Psychology and seven years of experience in mental health related fields; two other field representatives have Bachelor of Arts degrees and six years each of prior related experience. The fourth has completed three years work towards a Bachelor of Arts degree and had two years of related work experience.

In the class action office (Trenton), the supervising field representative holds a Masters degree in social work and had six years of prior related work experience. The second holds a Masters in Social Work and the third is a registered psychiatric nurse, who had eight years of prior related experience, including two years as a co-therapist for sex-offenders in the New Jersey prison system.

offices", the regional offices operate, in practical effect, as a partnership among all professionals on the staff. The ultimate service provided may be "legal" in nature (*i.e.* serving as counsel or, in the case of a juvenile, as guardian *ad litem* as well, at a legal proceeding such as a commitment hearing or a periodic review), but input into the final result comes from all staff members. The field representative interviews the patient/client initially[10] and gathers all data pertinent to the type of legal representation called for. In the case of a commitment hearing, the field representative will ascertain (1) the client's current medical/psychological condition as evidenced both by the hospital records and by the field representative's assessment of the client at the time of the interview; (2) the client's background—both social and medical—and current family situation; (3) the availability of alternative care facilities appropriate to the client's needs; (4) the need for recruiting independent psychiatric testimony to present on behalf of the client at the hearing. For periodic reviews, the field representative will obtain information pertinent to (1) through (4) above, and, in addition, will review

[10] In the case of a commitment hearing, where the client has been hospitalized under a temporary commitment order, under N.J.S.A. 30:4-37 and 30:4-38, the name is referred to the appropriate regional office by the Office of the County Adjuster in the county of the patient's residence. In the case of periodic reviews (see footnote 7, *supra*, at p. 6), the names of patients whose hearings have been scheduled are referred to the appropriate regional office by the Office of the County Clerk in the county of the patient's residence.

It should be noted that a bill before the State Legislature, S.1677, would totally revamp the involuntary civil commitment procedure, mandate the creation of county screening centers, and provide hearings for all patients within 72 hours of admission. The bill has passed the full State Senate as well as the Assembly Institutions, Health and Welfare Committee, and is now before the full Assembly.

the patient's history of hospitalization to evaluate the nature of the care and treatment rendered in an effort to determine if continued hospitalization is appropriate.

The field representative then confers and works closely with the attorney to develop the appropriate legal strategies in light of the individual patient/client's needs and desires. The attorney appears at the hearing as the patient/client's advocate, to advance that individual's desires to the maximum extent feasible, and to give the client a means of reaching outside the system for an examination of situations in which his rights as an individual citizen may have been violated. *Herr, supra,* at 11, citing Sen. Rept. 94-160, at p. 38. All final legal decisions concerning a given patient are thus bottomed on a joint effort by the several professions represented on the Division's staff.[11]

[11] The Division of Mental Health Advocacy thus provides representation in both individual and class matters in the systemic, organized way contemplated in and urged by the relevant scholarly literature. See, *e.g.*, Andalman and Chambers, "Effective Counsel for Persons Facing Civil Commitment: A Survey, Polemic and a Proposal," 45 *Miss. L.J.* 43, 75-76 (1974); Litwack, "The Role of Counsel in Civil Commitment Proceedings: Emerging Problems," 62 *Calif. L. Rev.* 816, 826, 839 (1974); Note, "The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill," 67 *Col. L. Rev.* 672, 689 (1967). For critiques of the role of the occasional or assigned counsel in such matters, see, *e.g.*, Cohen, "The Function of the Attorney and the Commitment of the Mentally Ill," 44 *Tex. L. Rev.* 424, 448, 450, 457-458 (1966); Weihofen, "Mental Health Services for the Poor," 54 *Calif. L. Rev.* 920, 939 (1966); "Developments in the Law—Civil Commitment of the Mentally Ill," 87 *Harv. L. Rev.* 1190, 1288 (1974) (hereinafter "Developments"); Comment, "Liberty and Required Mental Health Treatment," 114 *U. Pa. L. Rev.* 1067, 1068-1070 (1966).

B. Procedural rights for all individuals, including juveniles facing commitment to a mental institution, have been codified in N. J. Ct. R. 4:74-7.

Prior to September 8, 1975, New Jersey civil practice rules provided that a person facing civil commitment receive written notice of the time and place of the final hearing "at least *one day* before the date fixed." N.J. Ct. R. 4:74-7(e) (1969 rev.) (emphasis added). If the patient was not confined prior to the hearing, service was to be upon him or her personally or upon his or her attorney; if the patient was in an institution prior to the hearing, the county adjuster was required to effect personal service. The prior rules further provided that the "notice shall contain a statement that if the patient desires to oppose the application for a final judgment of commitment, he may appear personally or by attorney at the time and place fixed for the final hearing." *Id.* The decisions whether to hold an actual hearing and whether to have the patient present were completely discretionary with the court. N.J. Ct. R. 4:74-7(f) (1969 rev.).

However, following a trial court decision that a right to counsel attached to all commitment hearings, the State Supreme Court—faced with the contention that due process requirements under the Fourteenth Amendment to the United States Constitution and Art. I., Para. 1 of the New Jersey Constitution mandated the application of the full panoply of procedural due process guarantees in the involuntary civil commitment process[12]—both dismissed as moot a county's appeal from the lower court's ruling, and simultaneously promulgated revised N.J. Ct. R. 4:74-7

[12] The range of rights includes notice, hearing, right to be present, confrontation of witnesses, and, especially, the right to be represented by counsel.

(1975 rev.), mandating counsel at all such hearings, as well as at periodic reviews, and establishing a full range of due process safeguards at such hearings. *In re Geraghty*, 68 N.J. 209, 343 A. 2d 737 (1975). Subsequent to that 1975 revision of the rules, certain sections—specifically including several applying directly to juveniles—have been further amended, effective September, 1976.

The combined net effect of the current rule and pertinent statutes (N.J.S.A. 30:4-27 *et seq.*) is that civil commitment proceedings in New Jersey now involve, at the least, the following procedural provisions, as a matter of practice:[13]

(1) An order for temporary commitment must be based on an application supported by the type-

[13] Another challenge to the New Jersey civil commitment practice had been lodged in October 1973, in a federal court suit questioning the constitutionality of N.J.S.A. 30:4-37; 4-38; 4-41; and 4-42, as well as N.J. Ct. R. 4:74-7(b), (c), and (e) (1969 rev.). *Coll* v. *Hyland*, 411 F. Supp. 905 (D. N.J. 1976). The decision of the three-judge court in *Coll* was subsequent to the adoption of the 1975 revision of N.J. Ct. R. 4:74-7 and the decision in *In re Geraghty, supra.* Therefore, the Court weighed Coll's constitutional challenges in light of the new Rule and stated: "[W]e confine our inquiry to the constitutionality of the current rules of court, which are substantially different from those previously in effect." 411 F. Supp. at 907. The Court found the current New Jersey rule to provide constitutionally adequate procedural protections to persons facing involuntary civil commitment. Specifically, the Court rejected Coll's contention that a preliminary hearing was constitutionally required, citing the 20-day limit for final hearings in the New Jersey rule. The *Coll* Court went on to find that the procedures codified by the current New Jersey rule met constitutional muster. "After a thorough review of the New Jersey statutes and procedural rules governing civil commitments, we conclude that constitutional standards have been met. Accordingly, judgment will be entered in favor of the defendants." 411 F. Supp. at 913.

written or legibly hand printed certificates of two physicians licensed in any one of the United States, wherein each physician shall state the particular facts relied upon to support commitment;

(2) Such order must provide for a day and place certain on which the final commitment hearing is to be held, which shall be no more than 20 days from either the filing of the application, or the date of the temporary commitment order, or the date of admission of the client to the institution, as the case may be;[14]

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[14] N.J.S.A. 30:4-25 provides:

Classes of commitment

For the purpose of this Title the method of commitment of mentally ill patients shall be divided into 5 classes:

Class A. Where immediate temporary confinement in an institution is not necessary before making final order of commitment.

Class B. Where immediate temporary confinement is necessary, owing to the condition of the patient, and where an order of temporary confinement can be obtained before the patient is taken into such institution.

Class C. Where immediate confinement in an institution before making the temporary order hereinafter referred to is necessary, owing to the condition of the patient, and where an order of temporary commitment cannot be obtained before the patient is taken into such institution.

Class D. Where a person voluntarily applies for admission to an institution for treatment. In all such cases the admission and maintenance shall be governed by the provisions of section 30:4-46 of this Title.

(Footnote continued on following page)

(3) Counsel must be appointed, by the temporary commitment order, to unrepresented clients, and juveniles shall be assigned guardians *ad litem* who must be attorneys;

(4) Notice of the final hearing, which must be served *no less than* 10 days prior to such hearing, shall be personally served upon the patient, and shall also be served on the patient's counsel or guardian *ad litem*, the nearest relatives of the patient, the county adjuster and the superintendent of the institution where the patient is confined if such is the case;

(5) The patient, through counsel, has broad discovery rights, as well as the right to appointment of independent psychiatric experts without charge to the patients;[15]

(6) Oral testimony must be taken at the final commitment hearing from a licensed physician who has examined the patient since the date of the temporary order;

(Footnote continued from preceding page)

Class E. Where a person in confinement, under care of the chief executive officer of any correctional institution, is to be transferred to an institution for treatment. In all such cases the procedure shall be governed by the provisions of section 30:4-82 of this Title.

[15] This section of the rule, N.J. Ct. R. 4:74-7(d) (1976 rev.) incorporates the holdings of *Patients* v. *Kallen*, 123 N.J. Super. 175, 302 A. 2d 142 (App. Div. 1973); *In re Gannon*, 123 N.J. Super. 104, 301 A. 2d 493 (Somerset Cty. Ct. 1973), and *In re Alfred*, 137 N.J. Super. 20, 347 A. 2d 539 (App. Div. 1975).

(7) The patient must be present at the hearing unless good cause is shown for excluding him or her;

(8) A final order of commitment shall provide a schedule of periodic reviews to be conducted in the manner required for final commitment hearings;[16]

(9) If an order is entered at the final commitment hearing discharging a temporarily confined patient, such order may establish conditions for discharge such as attendance at a mental health care facility on an out-patient basis, *cf. State* v. *Carter,* 64 N.J. 382, 316 A. 2d 449 (1974).

Minors are afforded virtually the same procedural protection as adults in civil commitment proceedings irrespective of who makes the original application for the minor's commitment. Specifically with respect to juveniles, N.J. Ct. R. 4:74-7(j) (1976 rev.) provides:

> Institutionalization of Minors. A minor shall be institutionalized for the treatment of mental ill-

[16] The 1976 revised rules have changed the review schedule mandated for all confined patients. While adults are to be reviewed in a plenary-type hearing for the first time within three months from date of judgment, then again within six months from date of judgment and annually thereafter, minors' cases are required to be reviewed every three months until discharged or upon reaching majority. N.J. Ct. R. 4:74-7(f) (1976 rev.). Further, those patients whose condition is regarded as "irreversible," *i.e.,* suffering from either severe mental retardation or irreversible brain syndrome, are exempted from plenary review, provided notice of summary review is given to all interested parties—however, this exemption from plenary annual review does not commence until two years following the date of original judgment. *Id.*

> ness only upon court order entered in accordance with the procedures prescribed by paragraphs (b) through (g), inclusive, of this rule except that (1) Irrespective of whether or not he meets the standard of involuntary commitment stated by this rule, any minor 14 years of age or over may request his admission to an institution for psychiatric treatment provided the court on a finding that the minor's request is voluntary, enters an order approving the admission. If an order approving a voluntary admission of a minor is entered, the minor may discharge himself from the institution in the same manner as an adult who has voluntarily admitted himself. An order approving a voluntary admission shall be reviewable as provided by paragraph (f) of this rule, however, said review may be summary, and (2) This rule shall not be construed to require any court procedure or approval for the admission of a minor by his parent, parents, or other person in *loco parentis* to any institution for the evaluation or diagnosis of a mental condition provided the admission does not exceed seven days. If further hospitalization is then required, the applicant shall proceed in accordance with paragraph (e) of this rule. If an application for commitment is made during such admission, the final hearing shall be held within 20 days from such admission, adjournable only in accordance with subparagraph (e)(1) of this rule.[17]

[17] This provision of the rule differs substantially from the original 1975 revision which merely stated:

> Commitments of Minors. No minor shall be committed except temporarily to a mental institution for treatment and care

(Footnote continued on following page)

In addition, paragraph (b) of the rule specifically changes the standard of commitment for minors, as distinguished from the "probable danger to self or others" standard continued for adults. See N.J. Ct. R. 4:74-7(b) (1976 rev.):

> If the patient is a minor, the certificate may state, alternatively, the facts upon which the physician relies in concluding that the patient is in need of intensive psychiatric therapy which cannot practically or feasibly be rendered in the home or in the community or on any out-patient basis. *Id.*

The changes in the 1976 revision are thus fourfold: although the standard for commitment is now more "lenient" (*i.e.*, instead of the "probable danger to self or others" standards applicable to adults, juveniles may be committed also if found to be in need of intensive psychiatric therapy which cannot practically or feasibly be rendered in the home or in the community or on any out-patient basis), in at least three areas, juveniles are afforded additional procedural protections. Their commitments are periodically reviewed every three months from time of entry until the juvenile is either discharged or reaches majority, N.J. Ct. R. 4:74-7(f) (1976 rev.); the role of counsel is expanded to include the duties of guardian *ad litem*, N.J. Ct. R. 4:74-7(c)(2) (1976 rev.), which enables the attorney to employ all available resources—legal, medical and social, institutional and noninstitutional—to achieve a judicial result appropriate to the particular needs and wishes of the individual juveniles; further, special provisions are made for truly voluntary commitments whereby any minor 14 years of age or over may request his admission to an institution for psychiatric treatment, *provided* the court finds such a request is voluntary and enters an order approving such admission, N.J. Ct. R. 4:74-7(j)(1) (1976 rev.).[18]

(Footnote continued from preceding page)

> of an alleged mental condition on the application of his parent or other person in loco parentis except on court order after hearing pursuant to paragraph (e) herein. A guardian ad litem, who shall be a person other than the applicant for the commitment, shall be appointed by the court to represent the interests of the minor at such hearing.

N.J. Ct. R. 4:74-7(j) (1975 rev.).

Further, the 1976 amendment requires the guardian *ad litem* to be a person other than the applicant for the commitment. N.J. Ct. R. 4:74-7(c)(2) (1976 rev.). "This requirement is intended to provide the child with complete insulation in the legal sense from the applicant, who in most cases will be the parent or other person in *loco parentis.*" Pressler, *Current N.J. Court Rules*, Comment 4 to R. 4:74-7, at 829 (1976).

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[18] A minor committing himself voluntarily is, for discharge purposes, in the same category as adults who voluntarily commit themselves and, therefore, may, pursuant to the statute, discharge themselves on 72 hours' notice. See *In re Williams*, 140 N.J. Super. 495, 356 A. 2d 458 (Essex Cty. J.D.R. Ct. 1976).

C. In those juvenile commitment cases in which juveniles were represented by *amicus*, Department of the Public Advocate, Division of Mental Health Advocacy, there has been no evidence of exacerbation of familial situations; on the other hand, the dispositions bespeak individualized treatment by counsel and individualized determinations by the Court.

Since the promulgation of N.J. Ct. R. 4:74-7 (1975 rev.), field offices have undertaken to provide—in Mercer, Hunterdon and Essex counties—attorney and guardian *ad litem* services as required by N.J. Ct. R. 4:74-7(c)(2) and (j) (1975 rev.). This has involved the delivery of the four types of services discussed *supra* at pp. 8-9, but on a somewhat broader level than for adult clients. As will be discussed further below, the assignment of a guardian *ad litem* role to Division attorneys has placed these attorneys in a unique position *vis-a-vis* the court and the applicant for commitment. The role of counsel in juvenile commitment proceedings, as effectuated by Division attorneys, has taken on new dimensions of responsibility and authority.

As of August 1977, the two field offices combined represented approximately 213 juveniles since September 8, 1975 at civil commitment proceedings and at periodic review hearings. The vast majority of these clients have been between the ages of fifteen and seventeen, although the Division has represented children as young as seven years of age.[19]

In the 213 juvenile cases closed by the Mercer and Essex County field offices of *amicus* Department of the Pub-

[19] As of August 1, 1977, the precise breakdown in terms of age levels was as follows: age 7-1, age 8-10, age 9-4, age 11-8, age 12-10, age 13-10, age 14-12, age 15-40; age 16-49; age 17-37; unknown-7.

lic Advocate, Division of Mental Health Advocacy, since the September, 1975 revision to N.J. Ct. R. 4:74-7(j), the dispositions reveal a pattern of individualized court determinations.[20] In addition, the dispositions of the cases reveal that counsel—in New Jersey—fulfills those multiple functions urged by respected commentators. See, *e.g.*, Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions", 62 *Calif. L. Rev.* 840, 888-890 (1974) [hereinafter "Volunteering Children"] (discussed specifically at Point II, p. 32 *infra*); see also, Stone, *Mental Health and Law: A System in Transition* 59, 233-237 (1975)(hereinafter Stone I).

Thus, of the 213 closed files,[21] 34 of the juveniles were discharged following the involvement of *amicus* as counsel but prior to a formal hearing, 31 were released at such a hearing (in virtually all cases to their parents' or guardian's custody), 14 were "discharged pending placement,"[22] six were "discharged pending placement" to a facility administered by New Jersey's Division of Mental Retarda-

[20] All statistics are on file with *amicus* Department of the Public Advocate, Division of Mental Health Advocacy.

[21] In three cases the Division did not represent the juvenile because of lack of indigency, see, *e.g.*, N.J.S.A. 52:27E-26, 27, and, in one case, the juvenile eloped prior to the hearing.

[22] The phrase "discharge pending placement"—apparently unique to New Jersey practice—covers those cases in which orders are entered discharging patients subject to the availability of a suitable alternative care or aftercare facility. These orders are usually accompanied by retention of jurisdiction by the Court to insure that the placements are, indeed, made within the specific time limits contained in the order. *Cf. Dixon* v. *Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

tion,[23] 15 were "discharged pending placement," to a residential school,[24] one was "discharged pending placement" to a drug rehabilitation facility,[25] one was discharged to the custody of Division of Mental Retardation officials, four were discharged subject to certain conditions,[26] two were transferred to out-of-state hospitals,[27] three were ordered admitted to a special education program while institutionalized,[28] five were remanded to local jails or youth detention facilities to await trial on criminal offenses or hearings on juvenile delinquency petitions, or to a facility for "juveniles in need of supervision" [JINS"],[29] and one was discharged to a foster home. In addition, in two cases, adjournments were entered (so as to facilitate residential school placement and to avert the potentially stigmatic effect of a commitment label),[30] and in 38 cases, voluntary applications for admission were accepted.[31] Finally, in 22 cases commitment was ordered, and in 30 cases, confinement was continued.[32]

[23] See generally, N.J.S.A. 30:4-165.1 *et seq.*

[24] See generally, N.J.S.A. 18A:46-9, 13, 14, 15.

[25] See generally, N.J.S.A. 30:6C-5.

[26] *E.g.*, that the juvenile participate in a specific aftercare program.

[27] See generally, N.J.S.A. 30:7B-1 *et seq.*

[28] This, *e.g.*, requires the release of certain funds by the board of education in the municipality in which the juvenile resided. See generally, N.J.S.A. 18A:46-13, 14. *Cf.* 20 U.S.C.A. §1415 (effective October 1, 1977).

[29] See generally, N.J.S.A. 2A:4-45, 56, 57.

[30] See generally, "Volunteering Children," *supra,* at 845, 848.

These statistics reflect, then, individual determinations on individual bases. Dispositions are not limited to a finite commit/release paradigm (a fear often articulated by those who see the involuntary civil commitment process as taking on all of the trappings of the criminal trial);[33] on the other hand, they are specifically structured so that an individualized determination can be made—following the full participation of counsel at all relevant stages of the proceedings—in the manner contemplated by, *inter alia,* Ellis, Stone I and Cohen, all *supra.*

Significantly, in a lengthy and thoughtful analysis of this problem, Assistant United States Attorney John P. Pannenton has noted:

> Both the doctor and the minor's attorney should independently determine whether the child is being coerced into seeking psychiatric help. Then a search should be conducted to ascertain whether possible alternatives to institutionalization exist in the community. Outpatient treatment, special education programs, foster homes, and family counseling services, to name only a few, may further the child's interest far better than institutionalization. If the adult designated to represent the child finds

[31] See *In re Williams, supra;* N.J. Ct. R. 4:74-7(j) (1976 rev.).

[32] In two of the latter cases, special orders were entered ordering independent psychiatric evaluations of the juvenile. See, *e.g., In re Alfred, supra.*

[33] See, for such a view, Peszke, *Involuntary Treatment of the Mentally Ill* (1975).

> that his client wishes to contest the hospitalization, the role to be assumed by the adult is that of an adversary. As such, the skills of an attorney are required to prepare a proper defense and to obtain all relevant information which may prove beneficial to the child.

Pannenton, "Children, Commitment and Consent: A Constitutional Crisis," 10 *Fam. L. Q.* 295, 332 (1977) (hereinafter "Constitutional Crisis").

Indeed, the roles played by *amicus* in the cases in question have gone far beyond simple trial representation: in many of those cases in which *amicus* was appointed guardian *ad litem* as well as counsel,[34] orders were entered continuing the Division as guardian *ad litem* beyond the actual formal commitment (or acceptance of the voluntary application) so as to facilitate and insure the implemention of an aftercare plan. In other cases, *amicus* has played an active role in such areas as facilitation of school placement,[35] and unblocking of available funds for special educational programs, assisting the family in obtaining an appropriate community education program for the juvenile,[36] representing juveniles on individualized right to treatment,[37] or right to obtain Medicaid funds,[38] facili-

[34] See, N.J. Ct. R. 4:74-7(j).

[35] A corollary of such a role is, of course, its inverse: *amicus* also has acted to deter inappropriate placements.

[36] See generally, N.J.S.A. 18A:46-14.

[37] See, e.g., N.J.S.A. 30:4-24.1; *In re D.D.*, 118 N.J. Super. 1, 285 A. 2d 283 (App. Div. 1971).

[38] See generally, 42 U.S.C.A. §1396 *et seq.*

tation of an available family therapy program, provision of independent psychiatric expertise to the family so that the juvenile could readjust to his home setting after commitment,[39] resolution of conflicts between social service agencies (*e.g.*, Division of Youth and Family Services [DYFS]) and the juvenile's family, and finding suitable aftercare or alternative care placements. These various functions again, reflect a "counseling attitude" that far transcends the narrow range of choices often feared as a necessary concomitant to the presence of adversarial counsel.

In addition, it appears that—in most cases—parents were affirmatively pleased with the involvement of *amicus*. Although parents were hostile to the role of adversary counsel in a handful of cases, in the vast majority, parents were described by *amicus* counsel as "enthusiastic about our involvement," "thankful for involvement," "receptive," "cooperative," "positive," "helpful," "pleased," "grateful," "very involved," "appreciative," "supportive," and "interested and informative."

Interestingly, in at least four cases, parents who began with "negative" feelings or who were "uncooperative" with counsel, radically changed their attitudes during the course of representation and became "positive" or "cooperative" by the time of the final hearing.[40] In these

[39] In this case, following acceptance of the juvenile's own voluntary application, he was subsequently discharged and is now receiving out-patient treatment at home.

[40] As part of the preparation of this brief, the Mercer and Essex Regional Offices of the Division of Mental Health Advocacy were asked for statistical read-outs on their respective juvenile cases. One statistical category asked for "response of family" (to legal representation of the juvenile by Division attorneys), in response to which subjective answers such as those appearing in the text were received.

cases, it is most clear that counsel did not exacerbate tension; rather its presence actually served to alleviate such feelings and strengthen interfamilial bonds.[41]

Thus, it has been suggested that, "in a crisis situation, parents may go to the first facility about which they are told or to whatever facility is closest[,] . . . see[ing] hospital care as the only approach to the crisis." Note, "'Voluntary' Admission of Children to Mental Hospitals: A Conflict of Interest Between Parent and Child," 36 *Md. L. Rev.* 153, 160 (1976) [hereinafter "Conflict of Interest"]. The presence of outside counsel serves to help insure that this parental decision—often premised on incomplete or inaccurate information—is not made and ratified in a factual vacuum.[42] Similarly, it has been noted that, "[E]ven with benevolent motives, parents may in fact be acting adversely to the child's welfare." "Constitutional Crisis," *supra*, at 318. A newsletter published by the U.S. Department of Health, Education and Welfare points this out graphically:

[41] Another phenomenon worth noting is that, in those cases in which counsel either represented the juvenile on treatment questions or actively sought an after-care or out-patient program, in virtually all instances, parents were especially positive about Division of Mental Health Advocacy involvement. Thus, one casenote indicates, "Mother attended hearing; appreciates 'pushing' by DMHA [Division of Mental Health Advocacy] for placement" (client placed in appropriate facility for juveniles with learning disabilities); in another, where a juvenile was discharged to the custody of a "JINS" program administrator, the note reads, "Father interested: pleased with final disposition; participated in decision."

[42] The same author points out that this is especially a problem in families of lower socioeconomic status: "For poor families, dependent upon public institutions, their problem is compounded by a more limited number of resources from which to choose." *Id.*

> A small but steady stream of letters continues to flow in from parents whose children are in institutions for the retarded or mentally ill or who are contemplating commitment . . . it seems safe to say that most decisions to commit to a large institution are made only because no other choices are available. When parents are obliged to keep their children at home 24 hours a day, seven days a week because no education nor treatment programs will accept him, they are usually desperate for relief from an impossible burden of care. When they "choose" to place their child in an institution where conditions will work against the child rather than for him it is only because no other public alternatives are available . . .

Id. at 318-319, n.101, citing "Close Look Newsletter," (Special Information Center 1972).

Finally, the presence of counsel has led to exceptional judicial creativity in an area in which, most likely, such creativity would be conspicuously absent but for the presence of an adversarial role. In *In re Pamela T.*, Docket No. ESCC 16-68 (Essex Cty. J.D.R.Ct. 1975), a "treatment program" mainly consisting of over 200 electroshock applications and 23 hours a day in seclusion—structured in response to the "behavior problems" of a young girl with an organic brain condition—was struck down as violative of the Eighth Amendment's ban on cruel and unusual punishment;[43] in *In re Williams, supra,* the court

[43] *Cf. Rozecki* v. *Gaughan,* 459 F. 2d 6, 7 (1 Cir. 1972). The *Pamela T.* case received widespread press attention following entry of the court order. See *e.g.,* Jaffe, "Horror Story at Greystone Ends for Girl," *Newark Star-Ledger,* Vol. 62, No. 79, p. 1, col. 7 (May 12, 1975). All orders in juvenile commitment cases are on file with the Division of Mental Health Advocacy.

held that a juvenile—on his own—could voluntarily admit himself to an institution (thus avoiding the stigma inherent in an involutary commitment) if he "understood the nature of a voluntary commitment and grasped the significance of the . . . proceedings"; in *In re D.G.*, Docket No. HNCC 1-76 (Hunterdon Cty. Ct. 1976), the court held that all documents and records pertaining to the involuntary commitment proceedings be impounded "to protect the interests of the juvenile.[44] In *In re G.G.*, Docket No. MECC 164-75 (Mercer Cty. Ct. 1975), in which *amicus* represented a juvenile whose condition had been gravely deteriorating and on whom psychotropic medication was having no positive effect, and where both the juvenile's independent psychiatric expert witness and the hospital physician advocated the use of electroshock, *amicus* petitioned the court to determine the need for such treatment.[45] Following the hearing, the treatment was ordered

[44] This practice has been subsequently adhered to in all juvenile commitment matters.

[45] In a letter to the Court, the attorney arguing the case stated:

> In the case at hand, I believe it should be the role of counsel not to blindly resist treatment, but to assist the court in monitoring the decision process of the medical professionals. To this end, I intend to elicit testimony at the forthcoming hearing regarding the availability of alternatives to electric shock therapy, the risks associated with its use, and the chances for negative results in addition to testimony supporting the use, so that a detailed background will exist upon which the Court may render its decision.

Letter from Herbert D. Hinkle, Esq., counsel for juvenile, to Honorable George Y. Schoch, Assignment Judge, Superior Court, Law Division, Mercer County, N.J., November 26, 1975, in *In re G.G.*, *supra*.

and administered, and the juvenile has been subsequently discharged.[46]

In the case of a nine-year old autistic child, *amicus* successfully petitioned the court to prohibit the use of aversive, electro-prod therapy, unless rigorous standards for staff training and program management were met, *In re C.B.*, Docket No. MECC 8202 (Mercer Cty. Ct. 1976). As the hospital did not comply with the court-ordered conditions, a previously entered order mandating such "treatment" was subsequently vacated.[47]

In *In re M.V.R.*, Docket No. MECC 251-76 (Mercer Cty. Ct. 1976), the court ordered a local school board to reconvene from recess so as to immediately appropriate funds (the release of which would be otherwise blocked due to the recess) to provide specialized treatment for the juvenile in question.[48] In a case where the court had ordered a mentally retarded minor transferred from the state hos-

[46] This case is described in greater detail in Perlin, "The Right to Refuse Treatment in New Jersey," 6 *Psychiatric Annals* 300, 304 (1976).

[47] The Division is presently seeking placement for this child in a special residential school in Rhode Island which can provide trained experts to deal with the minor's particular illness. An earlier phase of the case is noted at Perlin and Siggers, 4 *Bull. Am. Acad. Psych. & L.*, *supra*, at 212, n.37.

[48] In another school funding case, where treatment had been delayed due to a refusal of several school boards to assume funding responsibility (due to frequent changes in domicile by the juvenile's family), the court ordered all of the boards to resolve the financial dispute, and ordered the juvenile discharged from the state hospital to an appropriate residential school with full funding. *In re J.M.*, Docket No. MECC 217-76 (Mercer Cty. Ct. 1976). *Cf. Bd. of Ed., Tp. of Little Egg Harbor* v. *Bds. of Ed. of Galloway Tp., et als.*, 71 N.J. 537, 366 A. 2d 977 (1976).

pital to a highly structured residential school (in a situation in which there was a sharp conflict among several interested relatives as well as between the relatives and the child herself), the court subsequently ordered that the juvenile be permitted trial home visits with different relatives (specifically prohibiting the use of any coercion or force by the relatives in attempting to overbear the girl's will regarding ultimate placement) and—in accordance with the girl's wishes—specifically prohibited outright discharge to her relatives prior to treatment at the residential school and prior to a reevaluation of the child's own final wishes as to placement. *In re T.W.*, Docket No. MECC 150-77 (Mercer Cty. Ct. 1977).

Finally, in a case where DYFS had begun to initiate custody proceedings so as to place a borderline mentally retarded child in a foster home, the court accepted the suggestion of *amicus* counsel to adopt the position of the child's treating physician at a child treatment center that the child remain with his parents after treatment to minimize the possibility of psychological regression likely to occur if he were to be removed to a foster home setting. *In re R.Z.*, Docket No. MECC 103-76 (Mercer Cty. Ct. 1977).

Cases such as these reflect the end results of the presence of counsel: the presentation to the courts of individual cases in a manner susceptible to individualized creative determinations. Clearly, fears as to the involvement of counsel appear groundless. A system which affords counsel and other procedural protections to juveniles facing commitment is eminently workable.

II. There is no indication that the presence of procedural due process safeguards is detrimental to juveniles; rather, the evidence is persuasive that such safeguards are beneficial to all parties involved in juvenile commitment matters.

Appellants argue, variously, that a "medically-indicated decision [made by a parent] for his child . . . has always . . . been considered to be . . . well within [the] . . . parameters [of the parent's responsibility and authority]," Ab at 15, that there is "little evidence in the record that psychiatry is an 'exact science,'" Ab at 18, that the "principals, *irrespective of how the case is styled,* are parents and their children," Ab at 30 (emphasis added), that "the system created by the Georgia Code for the voluntary hospitalization of mentally ill children works, and works well," Ab at 38, and that "additional or more formalized procedures are unnecessary, and . . . may be harmful and detrimental to the children," *id.*, noting specifically that "it is doubtful that a lawyer on cross-examination could get any more beneficial information than could a psychiatrist," Ab at 39.[49]

It is suggested that all of these arguments fall wide of the mark, and that both the empirical and scholarly literature effectively rebut each of these statements. In fact, it is likely that the absolute inverse of each of appellants' assertions is the more accurate assessment of the

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[49] Appellants specifically quote from the testimony of Dr. John Filley, one of their witnesses, as to the potentially disruptive effect of such hearings:

> Due process proceedings in the court, witnesses, and so on are . . . alien in a child's life and airs all the dirty linen, not all of it probably, but it airs a significant amount of dirty linen in the child's life and parents' lives. Ab at 40.

situation, and that the evidence is persuasive that due process safeguards benefit all parties—the juvenile, the parents, the relevant social service agencies and service providers, and the state—involved in juvenile commitment matters.

At the outset, it is by no means clear that the decision to commit a juvenile—possibly against that juvenile's will—is "well within [the] . . . parameters [of the parents' responsibility and authority]."[50] Speaking of custody and divorce proceedings, Anna Freud, Joseph Goldstein and Joseph Solnit argue forcefully that the presumption that a child's parents are "generally best suited to represent and safeguard his interests . . . should not prevail [where neither parents nor the State] . . . have a conflict-free interest in representing the child." Goldstein, Freud and Solnit, *Beyond the Best Interests of the Child* 65-66 (1973). In such cases it is "crucial [to make] . . . adequate provision for [the child's] . . . personal representation by counsel who has no other goal than to determine what is the least detrimental alternative for his client." *Id.* at 66. See also, Kleinfield, "The Balance of Power Among Infants, Their Parents, and the State,"

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[50] It should be noted that the familial situations of the named plaintiffs *sub judice* greatly diverge from the harmonious, unified relationship feared by appellants to be endangered by the introduction of counsel and other due process safeguards for the minor. J.R., removed from his natural mother by the State at three months of age, experienced no stable familial relationship during his frequently changed foster home stays; J.L., adopted at eight hours old, has seen neither his adoptive parents nor stepfather since April, 1974, when he was "voluntarily" committed to the State hospital. Their situations indicate the fallacy in appellants' arguments: in the very cases that were the original subject matter of this action, "parental responsibility and authority" had been either previously abdicated or was nonexistent.

Part I, 4 *Fam. L.Q.* 320, 323, 324 (1970) ("[W]ithout counsel, rights [of children] not only fail to be vindicated; they fail also to be created"); Note, "On the Voluntary Admission of Minors," 8 *Mich. J. L. Reform* 189, 213-214 (1974) ("In almost any context in which the status, position, or future placement of a minor is involved, the minor should be provided with counsel. It is simply unrealistic for another party to an action, who had his own interests with which to be concerned, to be expected to adequately safeguard those of a minor involved in the matter").[51]

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[51] Accord, Kleinfield, 4 *Fam. L.Q., supra,* at 347; Katz, "Children, Privacy and Nontherapeutic Experimentation," 45 *Am. J. Orthopsychiat.* 803, 807 (1975); Knitzer, "Child Advocacy: A Perspective," 46 *Am. J. Orthopsychiat.* 200 (1976).

This Court has articulated this argument in a similar context in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976), in striking down a Missouri statute which had required parental or other guardian consent to most first trimester abortions if the woman involved was under 18 and married. Although the Court noted that the Federal District Court had suggested there was a significant state interest in the safeguarding of the family unit and of parental authority, 392 F. Supp. 1362, 1370 (E.D. Mo. 1975), it rejected this as an across-the-board rule:

> It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to stregthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.

(Footnote continued on following page)

In fact, an approach contrary to that suggested by appellants appears to better comport with the reality of contemporary society: "With the increasing tendency of society to recognize and uphold individual interests, a unitary concept of protection could not be expected to protect adequately the interests of parent and child where those interests diverge." Wilkens, "Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors," 31 *Ariz. St. L.J.* 31, 69-70 (1975) (hereinafter "Removing the Barrier") (footnote omitted).[52]

Thus, in his seminal article on the right of children to independent counsel prior to "voluntary" civil commitment, Mental Health Law Project staff attorney James Ellis reviews the development of due process safeguards at juvenile delinquency proceedings and at involuntary civil commitment matters, notes the "negligible role" currently played by counsel in the juvenile commitment process, "Volunteering Children," *supra,* at 881, and sketches the multiple roles that independent counsel should have at such a hearing, including *inter alia,* ascertaining the juvenile's true wishes, explaining possible outcomes to the client (including, specifically, potential restrictivity of setting, alternative treatment modalities, facility regulations, etc.), counseling the client on consequences of hospitalization, and "present[ing] . . . [the client's] wishes in as effective a manner as possible." *Id.* at 888-889. He adds further:

(Footnote continued from preceding page)

428 U.S. at 75. *Cf. In re Smith,* 16 Md. App. 209, 295 A. 2d 283 (Ct. Spec. App. 1972) (mother could not force teenage daughter to have an abortion under applicable state law).

[52] The same author underscores that "the power of decision over one's own physical integrity certainly is not a fundamental element in the family unit." *Id.* at 70.

> Finally, while the lawyer should try to avoid becoming a middle person in future power struggles between the client and the hospital (or parents) because of the detrimental impact that might have on the client's acceptance of ordered treatment, it is appropriate for the attorney to reassure the client that counsel will again be available at the time of the periodic review of commitment, and may also be available if problems arise concerning in-hospital civil liberties. The knowledge that there is someone on the "outside" who is concerned about his or her fate after hospitalization may be one of the most valuable things a lawyer can give to a child-client.

Id. at 890 (footnote omitted).[53]

Again it should be emphasized that:

> Recognition of minors' rights of self-determination will not contribute to the dissolution or func-

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[53] Stone I, *supra,* at 59, makes appoving reference to a similar list of attorney functions prepared by Cohen, 44 *Tex. L. Rev., supra,* similar to the ones suggested by Ellis, and notes:

> Surely, some of the aforementioned functions are social service roles which far transcend what has traditionally been viewed as the attorney's function, but if the attorney does not fill some of these needs, it is unlikely that anyone else will; and without aid of counsel, commitment can easily become a summary or self-fulfilling process. There are, increasingly, lawyers who understand and are willing to fill these needs. And if counsel come to be perceived as co-workers in the mental health system, dedicated to the aforementioned array of purposes, and not merely as righteously contentious obstructors, their presence during the commitment process will be welcomed rather than dreaded.

See also, Stone I, *supra,* at 233-237.

> tional breakdown of the family unit merely because the sometimes divergent interests of parents and children create a conflict in the parental consent doctrine, a doctrine formulated for the protection of both these interests. Role differentiation . . . should not be taken necessarily as a sign that the family unit is disintegrating.

"Removing the Barrier," *supra* (footnote omitted). It is suggested that this argument of appellants is without merit.

Similarly, appellants' suggestion that there is "little evidence" as to the inexactitude of psychiatric diagnosis and inaccuracy of psychiatric predictions is, simply, inaccurate. In fact, the evidence is, on the other hand, overwhelming that psychiatrists are no more significantly predictively accurate than non-psychiatrists (*e.g.*, lawyers). See Rappeport, Lassen, and Gruenwald, "Evaluation and Follow-up of Hospital Patients who had Sanity Hearings," in Rappeport ed., *Clinical Evaluation of the Dangerousness of the Mentally Ill* 89 (1969) ("The comparison between court released and hospital released adjustment rates shows no significant difference in the predictive accuracy of either institution"), and Ennis and Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," 62 *Calif. L. Rev.* 693, 749 (1974) (no evidence found that a physchiatrist can predict dangerousness more accurately than a lawyer). In fact, a recent report prepared by the American Psychiatric Association concludes that "neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness.'" American Psychiatric Association, *Clinical Aspects of the Violent*

Individual 28 (1975).[54] It would appear, thus, that appellants' argument on this point similarly is not supported by the relevant data.

Further, it appears that the participants in cases of this sort cannot be styled into the simplistic parent/child dyad suggested by appellants. This is especially so in light of the evidence which suggests that, in many in-

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[54] Of course, in the famous study of the so-called "Baxstrom patients" (those persons ordered released from New York's maximum security facilities for "insane criminals" following this Court's decision in *Baxstrom* v. *Herold*, 383 U.S. 107 (1966)), it was found that, of the 969 *Baxstrom* patients who had previously been statutorily incarcerated in maximum security facilities, within one year, only *seven* were recommitted to such a facility on a finding of dangerousness (although it had been predicted by hospital officials that nearly 250 would need that type security), and, of the 147 patients released to the community, only one had been arrested within that time period (for petty larceny). Hunt and Wiley, "Operation *Baxstrom* After One Year," 124 *Am. J. Psychiat.* 124 (1968), reprinted in Association of the Bar of the City of New York, *Mental Illness, Due Process and the Criminal Defendant* 224 (1968). The *Baxstrom* patients have received special behavioral scrutiny. See, *e.g.*, Steadman, "Follow-up on Baxstrom Patients Returned to Hospitals for the Criminally Insane," 130 *Am. J. Psychiat.* 317 (1973); Steadman and Cocozza, *Careers of the Criminally Insane* (1974). For a more recent evaluation and survey of the relevant literature, see Steadman and Cocozza, "We Can't Predict Who Is Dangerous," *Psychology Today* 32 (January 1975). See also, *e.g.*, Dershowitz, "The Law of Dangerousness: Some Fictions About Predictions," 23 *J. Legal Ed.* 24 (1971); Steadman, "Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychiatry," 1 *J. Psych. & L.* 409 (1973); Wenk, Robison and Smith, "Can Violence Be Predicted?" 18 *Crime & Delinq.* 393 (1972); Kozol, Boucher, and Garofola, "The Diagnosis and Treatment of Dangerousness," 18 *Crime & Delinq.* 371 (1972); Dershowitz, "Dangerousness as a Criterion for Confinement," 2 *Bull. Am. Acad. Psych. & L.* 172 (1974).

stances, the decision to institutionalize a child is quickly followed by abandonment on the part of the parents, and that there are negative effects associated with institutionalization which are antithetical to any theory of well-functioning family development.

While recognizing the tremendous importance of a minor's having a stable, functioning relationship with parents, Pannenton warns of the devastation a minor would suffer if he were to be faced with a situation in which the controlling adult in his life were unable to provide this needed strength and in which he would be simultaneously deprived of independent, objective counsel to safeguard his rights:

> It is clear that a child who is confined to a mental hospital receives none of the benefits of developing in a healthy family environment. Instead, the child is isolated from his family both physically and psychologically and is forced to substitute hospital personnel and other patients for his basic emotional needs. The process of child development remains partially a mystery, but it is accepted by most experts that the one factor necessary for healthy development is a reasonable continuity with parental figures. Therefore, children are more frequently best served by remaining in their natural homes whenever possible. Even with this principle in mind, it should be recognized that there are times when the family neither can be nor wants to be so effective. In these instances, an innocent child should not be made to suffer as a result of the family's limitations, but instead should be afforded individual rights for his own protection.

"Constitutional Crisis," *supra,* at 329 (footnote omitted).

An alarming illustration of the feared abandonment of children devoid of any objective legal guardian is starkly presented by a follow-up study involving the plaintiffs in *New York State Association for Retarded Children* v. *Rockefeller,* 357 F. Supp. 752 (E.D.N.Y. 1973) [hereinafter *NYSARC I*], supplemented *sub nom. New York State Association for Retarded Children* v. *Carey,* 393 F. Supp. 715 (E.D.N.Y. 1975). In that study, it was found that during the course of litigation approximately ten percent of the parents of those minors involved in the case had either relocated, failing to leave a forwarding address, or had refused to respond to inquiries directed to them, and thus, could not be found. Either possibility points to an objective lack of concern shown by a significant number of parents for their mentally retarded children.[55] See Post-Trial Reply Memorandum for Plaintiffs at 3, *NYSARC I, supra,* as cited in Note, "Civil Rights—Right to Treatment—Neither Due Process nor Equal Protection Clause of the Fourteenth Amendment Guarantees the 'Right to Treatment' for Mentally Retarded Children Confined in a State Institution Through Noncriminal Procedures," 2 *Fordham Urban L.J.* 363, 367 (1973).

Significantly, numerous authorities have warned that "the negative, antitherapeutic effects of institutionalization often counteract processes of natural or induced remission in mental dysfunction, thus producing more psychologic harm than good," Saphire, "The Civilly-Committed Public Mental Patient and the Right to Aftercare," 4 *Fla. St. U.L. Rev.* 232, 247 (1976). A phenomenon,

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[55] As there were some 5700 residents of Willowbrook at the time of the litigation, 357 F. Supp. at 755, nearly 600 parents, thus, had chosen to absent themselves from their children's lives.

termed "iatrogenic illness"—the intensification of illness caused by the *fact* of hospitalization itself—can thus result from a prolonged stay in a mental institution. Yolles, "Mental Health's Homeostatic State: A New Territory," 7 *Int. J. Psych.* 327, 328 (1969); Kantor and Gellineau, "Making Chronic Schizophrenics," 53 *Mental Hygiene* 54 (1969).

Other authorities have stated that the need to institute guaranteed independent counsel for minors is of paramount importance. Each delay in granting minors such safeguards may be critical to the well-being of countless children:[56]

> We cannot continue to risk the emotional, psychological and physical well-being of children and young adults at the price of parental consent. In such sensitive areas as birth control, pregnancy, drug abuse and emotional problems, seeking parent-

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[56] The cause for alarm is not unfounded. Ellis suggests that parents in recent years have resorted to "voluntary" commitment in reaction to the counter-cultural values and lifestyle they saw their children embracing. The parents' own visceral reactions thus motivated their decision in many instances. "Volunteering Children," *supra,* at 851. In addition, of course, societal pressures and personal feelings may also interfere with parental ability to decide upon the appropriate course of conduct:

> The parent may be motivated to ask for such institutionalization for a variety of reasons other than the best interests of the child himself, *i.e.,* the interests of other children in the family, mental and physical frustration, economic stress, hostility toward the child stemming from the added pressures of caring for him, and perceived stigma of mental retardation.

"Conflict of Interest," *supra,* at 169, n.80, citing Murdock, "Civil Rights of the Mentally Retarded—Some Critical Issues," 7 *Fam. L.Q.* 1, 10 (1973).

> al consent may be particularly counter-productive. Marker and Friedman, "Rethinking Children's Rights," *Children Today,* 74-14 DHEW Pub. No. (Nov.-Dec. 1973).

Again, it appears that appellants' position is unpersuasive.

Appellants argue further that the Georgia system "works and works well." Unfortunately, they cite absolutely no empirical evidence to support this allegation. In reality, it is likely that, without the provision of counsel, if the system "works," it can "work" only to the detriment of the juveniles involved. As will be discussed below, see pp. 41-42 *infra,* counsel plays a significant, even dispositive role, in commitment proceedings. It strains credulity to suggest that a system which does not provide this basic right—accurately characterized by this Court as one of those "immutable principles of justice which inhere in the very idea of free government," *Powell* v. *Alabama,* 287 U.S. 45, 71 (1932), quoting *Holden* v. *Hardy,* 169 U.S. 366, 389 (1898),—"works and works well." *Cf. State ex rel. Memmel* v. *Mundy,* 75 Wis. 2d 276, 249 N.W. 2d 573 (Sup. Ct. 1977) (upholding trial court order appointing legal aid society to represent *all* indigent patients in civil commitment proceedings).

Significantly, in its decision two years ago in *O'Connor* v. *Donaldson,* 422 U.S. 563 (1975), this Court characterized a similar argument as "unpersuasive," adding:

> Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present. *Id.* at 574, n.10.

Indeed, as Federal Judge David Bazelon has pointed out:

> When the limited function of a judge in reviewing administrative determinations is borne in mind, there seems little to distinguish psychiatry from, say, radio broadcasting. No judge would claim the ability to provide a particular therapy for a "chronic undifferentiated schizophrenic." But neither would any judge allocate frequencies to avoid interference. That is not his task in any case; his role rather is to determine whether a capable expert has studied the problem fully and reached a defensible result.

Bazelon, "Implementing the Right to Treatment," 36 *U. Chi. L. Rev.* 742, 745 (1969).[57] There is no evidence that the Georgia "model'" meets Judge Bazelon's well-articulated standards.

Finally, appellant argues that due process procedures are "unnecessary" and potentially "harmful and detrimental" to juveniles. This position, it is submitted, flies

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[57] Judge Bazelon has also dryly commented:

> . . . Diffidence in the face of scientific expertise is conduct unbecoming a court. Very few judges are psychiatrists. But equally few are economists, aeronautical engineres, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed dam on fish life, while they reject a similar scrutiny on the effect of psychiatric treatment on human lives . . . It can hardly be said that we are more concerned for the salmon than the schizophrenic.

Id. at 743; see also, Bazelon, "Psychiatrists and the Adversary Process," *Scientific Am.*, Vol. 230, No. 6 (June 1974), at 18, 23.

squarely in the face of the entire history of procedural due process jurisprudence in this country.

It is clear that counsel plays a critical, and in some cases, nearly dispositive role in involuntary commitment proceedings—where active attorneys are employed, fewer persons are committed, "Developments," *supra,* at 1285; Wenger and Fletcher, "The Effect of Legal Counsel on Admissions to a State Mental Hospital. A Confrontation of Professions," 10 *J. Health & Soc. Behavior* 66, 69 (1969) (74% of represented persons studied were released; only 9% of those not represented discharged); Kumasaka and Stokes, "Involuntary Hospitalization: Opinions and Attitudes of Psychiatrists and Lawyers," 13 *Comprehensive Psych.* 201 (1972); Kramer, "Protective Legal Services for the Mentally Ill," 23 *Hosp. & Commun. Psych.* 41, 42 (1972) (study of Mental Health Information Service in New York revealed 40.4% of all patients requesting hearings through counsel released by hospital psychiatrists prior to hearing), and that "intervention by counsel acting as patient's attorney tremendously increases chances of discharge, not to mention the other alternatives to hospitalization that may also be worked out to the patient's satisfaction," Gupta, "New York's Mental Health Information Service: An Experiment in Due Process," 25 *Rutgers L. Rev.* 405, 438 (1971). See also, Silverberg, "The Civil Commitment Process: Basic Considerations," in 1 *Legal Rights of the Mentally Handicapped* 103, 109 (Ennis and Friedman eds. 1973).[58]

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[58] Significantly, this conclusion was adopted in *Lessard* v. *Schmidt,* 349 F. Supp. 1078, 1099 (E.D. Wis. 1972), vacated on other procedural grounds 414 U.S. 473 (1974), on remand 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded on other grounds 421 U.S.

(Footnote continued on following page)

Specifically, *amicus'* experience in New Jersey similarly reveals that Division attorneys were "successful"[59] in nearly three out of every four individual representations: these statistics merely further corroborate those studies

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(Footnote continued from preceding page)

957 (1975), reinstated 413 F. Supp. 1318 (E.D. Wis. 1976), as evidence that the traditional guardianship appointment does not satisfy constitutional requirements for counsel as it is not sufficiently an advocacy role. See also, Dix, "Hospitalization of the Mentally Ill in Wisconsin: A Need for Reexamination," 51 *Marq. L. Rev.* 1, 33 (1967); *Quesnell* v. *State,* 83 Wash. 2d 224, 517 P. 2d 568, 576 (Sup. Ct. 1974) (citing *Lessard* with approval).

See Epstein and Lowinger, "Do Mental Patients Want Legal Counsel? A Survey," 45 *Am. J. Orthopsychiat.* 88, 91-92 (1975) (majority of patients studied indicated need for legal aid in both court-related hospitalization proceedings as well as in non-hospital-related matters). The authors note that the effects of legal aid would include a diminution of the numbers of persons involuntarily committed, heightened efficiency of hospital operations (counsel serving as an effective check to insure the presence of therapy), and a change in the image of the hospital as a "total institution." Significantly, the authors point out that the process of conducting the survey was "not traumatic to either the patient or the institution." See also Steadman, *A Program for Mental Health Advocacy Services for Pennsylvania: The Independent Evaluation of the American Bar Association's Pilot Project* 22 (1977) [hereinafter Steadman I] (70% of patients surveyed indicated they would seek further advocacy assistance.

[59] The word "successful," simply, means the attainment of a client's objective. Usually this will refer to cases in which patients are released from a psychiatric hospital, transferred to a less restrictive environment, alternative or institution, or where a treatment objective is obtained.

cited, *supra.*[60] It should also be noted that, through the intervention of *amicus* as counsel, juveniles in New Jersey are able to truly voluntarily admit themselves to institutions, thus, avoiding the stigma of commitment if they understand "the nature of a voluntary commitment and grasp . . . the significance of the proceedings," *In re Williams, supra;* this effectively rebuts appellants'

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[60] Illustratively, in the 5281 cases closed by the Mercer and Essex Field offices from the time of the Division's creation in the summer of 1974 until July 1, 1976, of the 4330 cases litigated beyond the referral stage, the Division obtained relief for 3140 clients (73%).

Thus, excluding those 755 cases in which clients were advised and assisted or referred to other agencies, the Division prevailed in 2783 of 3557 (78%) litigated nonperiodic review cases (including civil commitment, *habeas corpus* and individual treatment matters). These included 1576 cases in which clients were released to the community prior to a hearing, 419 in which they were transferred to less restrictive institutions, environments or conditions, 726 in which a *habeas corpus* petition was granted, or commitment was denied, and 27 in which a right to treatment/patients' rights petition was granted. In five cases, treatment claims were denied, and in 771 cases, either *habeas corpus* was denied or commitment was ordered.

Again, after excluding those 73 cases in which clients were advised and assisted or referred, the Division was successful in 346 of 762 (45%) litigated periodic review matters. In the 346 cases, clients were either released to the community or transferred to a nursing home, health care service facility, or other less restrictive facility, while in 416 cases commitment was continued.

Finally, the Division was successful in 11 of 11 (100%) litigated cases brought pursuant to *State* v. *Krol,* 68 N.J. 236, 344 A. 2d 289 (1975), governing commitment and review proceedings for persons found "not guilty by reason of insanity" under N.J.S.A. 2A:163-3.

All statistics are on file with the Division. See generally, Department of the Public Advocate, "Second Quarter Report" (1977), at 7, 11; for an earlier statistical overview, see Perlin and Siggers, 4 *Bull. Am. Acad. Psych. & L. supra,* at 211-212, n.30.

contention that the importance of procedural due process would "forc[e] [a child] to engage in an adversarial hearing irrespective of whether he desires to do so." Ab at 41.

Importantly, Dr. Eli Charles Messinger, an expert witness for the juveniles in the District Court in this matter, points out several ways in which the family would benefit from the provisions of due process protection for the child. All parties would have an opportunity to air their differences in an open and forthright manner:

> Rather than masking family disputes and difficulties, they would be recognized so they could be dealt with more constructively. Emphasis would be placed on developing a comprehensive picture of the events that have led parents to seek institutionalization of the juvenile. This effort at fact finding in itself would have a therapeutic effect on the child and family; for some it would be the first time that they will have been exposed to all sides of the story.

"Conflict of Interest," *supra,* at 173.

He also sees counsel, in addition to actually aiding a family in conflict by providing the objective negotiating tools of the law and due process, as providing a specific service needed by hospital staffs yet otherwise largely unavailable:[61]

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[61] The often disinterested role of counsel who represent psychiatric facilities is well-documented. See *O'Connor,* 422 U.S. *supra,* at 578, n.1 (Burger, C.J., concurring) ("[On remand], I would hope these sensitive and important issues would have the benefit of more effective presentation and articulation on behalf of petitioner"). See also, Stone, "Treatment Rights and Civil Liberties," in American Bar Association, *National Conference on the Legal Rights of the Mentally Disabled* 1, 10 (1976) ("Judging from the quality of the briefs [on behalf of defendant hospitals in litigation involving the mentally disabled], the attorneys who prepare them have little interest and even less dedication").

> Mental health professionals would be under self-imposed pressure to find such alternatives rather than have to defend questionable hospitalization recommendations. The juvenile's attorney would also have an opportunity to add his or her resources and talents to the search. In some cases, the necessity for a hearing would be avoided because satisfactory alternatives to hospitalization would have been secured. Rather than discouraging people from seeking treatment for juveniles, services would be provided that were better fitted to the child's and family's needs.

"Confiict of Interest," *supra.*

See generally, Davidson, "That Other Helping Profession," 122 *Am. J. Psych.* 691, 692 (1965) ("[D]ue process may be annoying but it is a barricade to the march of tyranny"). Use of counsel in this context, furthermore, would help to correct the currently-existing situation (discussed at Point I.A., footnote 11, *supra,* at p. 9) in which "courts and attorneys . . . to a great degree have abdicated their responsibility," and in which "powers historically reserved for the legal system have slowly eroded." "Constitutional Crisis," *supra,* at 309.[62]

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[62] Another commentator has observed that "the judicial default reflected in the legal handbag of the mentally ill is certainly most egregious." Shah, "Some Interactions of Law and Mental Health in the Handling of Social Deviance," 23 *Cath. U. L. Rev.* 674, 712 (1974), cited in "Constitutional Crisis," *supra,* at *id.,* n.61.

Thus, an analysis of a mental health advocacy project in Pennsylvania noted favorably:

> Moreover, there was a general appreciation among all professionals interviewed that the Project had provided patients

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In fact, courts have consistently held that the right to counsel does apply to those proceedings "in which the liberty of an individual is at stake . . . whether [or not] the proceedings be labeled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency," *Heryford* v. *Parker,* 396 F. 2d 393, 396 (10 Cir. 1968); see also *In re Gault,* 387 U.S. 1 (1967).[63]

(Footnote continued from preceding page)

> with much-needed protection. One professional spoke of the Project as having reached out to patients who had "fallen between the slats". There was universal agreement that the project had highlighted for mental health professionals their own shortsightedness in dealing with patients, and their relative insensitivity to human and legal rights. There seemed to be gratitude expressed that the lawyers had accentuated what the hospital staff now perceived as a significant deficiency in their treatment of patients, and a readiness to change the previous patterns of awareness.

Steadman I, *supra,* at 30.

[63] Of course, in other areas of substantive law involving the rights of those institutionalized in psychiatric facilities, Federal courts have willingly applied to juvenile cases the reasoning of decisions originally rendered in matters involving adults. See, *e.g., Morales* v. *Turman,* 364 F. Supp. 166, 175 (E.D. Tex. 1973), supplemented 383 F. Supp. 53 (E.D. Tex. 1974), reversed and remanded 535 F. 2d 864 (5 Cir. 1976), reinstated —— U.S. ——, 97 S. Ct. 1189 (1977), applying the law of *Wyatt* v. *Stickney,* 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), aff'd *sub nom. Wyatt* v. *Aderholt,* 503 F. 2d 1305 (5 Cir. 1974) (right to treatment); *King* v. *Carey,* 405 F. Supp. 41 (W.D.N.Y. 1975), applying the law of *Wyatt, supra* (applicability of Thirteenth Amendment), and *Souder* v. *Brennan,* 367 F. Supp. 808 (D.D.C. 1973) (right to compensation for labor providing consequential economic benefits to institution).

In cases involving the right of a mentally handicapped child to a free public education, see, *e.g., Pennsylvaia Association for Retarded Children* v. *Pennsylvania,* 343 F. Supp. 279, 303-306 (E.D. Pa. 1972) [hereinafter *P.A.R.C.*], wherein each child is entitled to a due process hearing as to his placement and/or special class assignment, such judicial intervention had been seen by some as "a substantial threat to the stability of the education system," Weintraub and Abeson, "Appropriate Education for all Handicapped Children: A Growing Issue," 23 *Syr. L. Rev.* 1037, 1057 (1972), as an infringement upon the "exclusive province of the schools," Kirp and Kirp, "The Legalization of the School Psychologists' World," 14 *J. School Psychol.* 83, 87 (1976),[64] and had been greeted, in some quarters, by "willful noncompliance" on the part of school districts, "Legal Reform," *supra,* at 52, quoting First and Interim Report of the Masters at 69 (filed Aug. 2, 1973), in *P.A.R.C., supra,* and by "resistance" on the part of many vocational educators, "Legal Reform," *supra* at 71-72. See generally, Herr, "Retarded Children and the Law: Enforcing the Constitutional Rights of the Mentally Retarded," 23 *Syr. L. Rev.* 995 (1972).

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[64] Similarly, following the decision of the District Court in *Mills* v. *Board of Education,* 348 F. Supp. 866, 875 (D.D.C. 1972) (due process requires a hearing prior to "exclusion, termination or classification into a special program"), a teachers' union leader direly warned that his group could not be "held responsible for the education of any child in the district while forced [by *Mills*] to keep unruly children in school." Kirp, Buss and Kuriloff, "Legal Reform of Special Education: Empirical Studies and Procedural Proposals," 62 *Calif. L. Rev.* 40, 89 (1974) [hereinafter "Legal Reform"], quoting *Washington Post,* May 2, 1973, at C-1, Col. 7. *Cf. Goss* v. *Lopez,* 419 U.S. 565 (1975).

Interestingly, although counsel at due process hearings was not made mandatory,[65] parents represented by counsel were "significantly more likely to win a favorable ruling" than those not so represented, "Legal Reform," *supra,* at 79, results which closely parallel findings of similar surveys involving involuntary civil commitment hearings, see, *e.g.,* articles cited at Point II, p. 41, *supra.* Significantly, in discussing the scope of the due process hearing, Kirp, Buss and Kuriloff point out:

> It is wrong, of course, to assume that the parents' and the child's interests will never vary. Sometimes they will clearly conflict. For example, a parent may want to "get rid of" a child he considers a nuisance or a burden, or might resist appropriate and beneficial placement in a particular special education program because he fears some resulting stigma. Often such conflicts cannot be detected, and, to some extent, parent-child conflicts must simply be tolerated. Nevertheless, the governing procedures should include a provision for appointment of a guardian *ad litem* to represent the child's separate interests when there is evidence of a significant conflict of interest.

"Legal Reform," *supra,* at 125-126.

Finally, if a child is not afforded due process, it is likely that the resulting institutionalization will not result in any "lasting peace" in the family. "Conflict of

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[65] Under the *P.A.R.C.* decree, a parent is notified he has the "right to be represented at the [due process] hearing by any person of his choice, including legal counsel," 343 F. Supp. at 304, but no explicit provision is made for appointment of counsel to the indigent.

Interest," *supra.*[66] It has been suggested, thus, that judicial nonintervention supports the integrity of the family unit only in the sense that it allows the parents in a dysfunctional family to deny the existence of real family problems by "blaming them on the illness of one of their children." "Volunteering Children," *supra,* at 854-855.[67] Such "artificial domestic tranquility," "Conflict of Interest," *supra,* should not serve as a rationalization for the denial of procedural due process. In this context, the suggestion by appellants' expert witness that "dirty linen" should not be aired must be emphatically rejected.

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[66] As noted in a lengthy analysis of problems posed by medical treatment of minors, "Preservation of the family relation in the medical setting is better accomplished by an honest and clearly articulated separation of the interests and obligations of each of the participants. The family relation has value only in the worth that the members place upon each of the other members." "Removing the Barrier," *supra,* at 71.

[67] Significantly, in the course of an article otherwise advocating parental autonomy and minimal state supervention in juvenile medical care matters, Joseph Goldstein carves out a major exception in the area of mental illness. Goldstein, "Medical Care for the Child at Risk: On State Supervention of Parental Autonomy," 86 *Yale L.J.* 645, 661 (1977). He notes specifically:

> In the case of "mentally ill" 16-year-olds, these modifications of parental autonomy silently rest on a not totally unwarranted suspicion that mental institutions provide little, if any, medical treatment, and more openly upon a fear of parental abuse, not unlike the exploitation of the system by members of a family wishing to put a difficult spouse, parent, or sibling out of sight. The reasons which seem to underlie renewed challenges to the commitment of adults for mental health care without their consent prompt and seem to justify a limited emancipation of children in this area.

Id. (footnote omitted).

The District Court in *Bartley* v. *Kremens,* 402 F. Supp. 1039 (E.D. Pa. 1975), vacated and remanded on other grounds —— U.S. ——, 97 S. Ct. 1709 (1977), astutely concluded that the application of due process would provide the necessary balance between the rights of parents and children in the particular area of commitment proceedings. That decision in no way denigrated the importance of the family; rather, it encouraged families to settle their problems in an open and equitable manner. The court's respect for the family is evidenced in its statement that:

> This finding does not mean that when considering whether or not to institutionalize a child, the state should ignore the opinions and observations of the child's parent. Rather the commiting authorities should listen carefully to parents who live with and observe the child on a daily basis for they very likely have invaluable information concerning their child. 402 F. Supp. at 1048.

One commentator, thus, has pointed out that the *Bartley* District Court's opinion "emphasizes . . . factfinding, not blamelaying," Note, 48 *U. Colo. L. Rev., supra,* at 258, adding that the *Bartley* safeguards "are likely to reassure parents that their child's best interests will be served," and that "*Bartley* procedures may be the most effective means of protecting the best interests of the child," *Id.*[68]

Thus, it appears that the imposition of procedural due process protections will not inure to the juveniles' detriment, but, rather, that such protections will insure that no

[68] The article in question specifically notes that this proposition is supported by the New Jersey experience. *Id.*

other patients will ever "fall . . . between the slats," Steadman I, *supra,* in a context which will "contribute substantially to family understanding and harmony in addition to protecting the interests of the child," "Conflict of Interest," *supra.*

CONCLUSION

On the basis of the foregoing, it is respectfully submitted that the judgment and decree of the District Court should be affirmed.

Respectfully submitted,

STANLEY C. VAN NESS
Public Advocate
State of New Jersey
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Date: August 22, 1977

[APPENDIX FOLLOWS]

APPENDIX

Letter from Joseph J. Levin, Jr., Counsel of Record for Appellees, and R. Douglas Lackey, Assistant Attorney General, State of Georgia to Mr. Michael Rodak, Clerk, U. S. Supreme Court

GEORGIA LEGAL SERVICES PROGRAMS
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August 25, 1977

Mr. Michael Rodak
Clerk, U. S. Supreme Court
Washington, D. C. 20543

Re: *Parham* v. *J.L. and J.R.*, U.S. Supreme Court Docket No. 75-1690, Consent To Filing of Amicus Briefs

Dear Mr. Rodak:

This is to inform the Court that counsel for both parties have agreed to the filing of the following amicus briefs in the above case:

1. American Bar Association
2. The Mental Health Law Project
3. Children's Defense Fund
4. Youth Law Center on behalf of the Child Welfare League of America

Letter from Joseph J. Levin, Jr., Counsel of Record for Appellees, and R. Douglas Lackey, Assistant Attorney General, State of Georgia to Mr. Michael Rodak, Clerk, U. S. Supreme Court

5. American Psychiatric Association
6. Department of the Public Advocate Division of Mental Health Advocacy State of New Jersey

Sincerely,

s/ JOSEPH J. LEVIN, JR.
Counsel of Record for Appellees

s/ R. DOUGLAS LACKEY
Assistant Attorney General,
State of Georgia

JJLJr:mhw

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

RICHARD J. HUGHES
Chief Justice

State House Annex
Trenton, New Jersey
No. 4-74

November 12, 1974

MEMORANDUM TO: All Assignment Judges, Trial Court Administrators and County Clerks

FROM: Chief Justice Richard J. Hughes

RE: Involuntary Civil Commitment Proceedings

A study recently conducted by the Administrative Office of the Courts indicates that there is a lack of uniformity among the counties in regard to the docketing procedures being followed in civil commitment cases. A great divergence of practice occurs in involuntary proceedings, where in many instances, papers are not filed until after the final judgment of commitment. (See N.J. S.A. 30:4-56). In addition, lack of adequate docketing procedures has permitted uncontrolled administrative adjournments so the court does not have a written record of the patient's confinement. When notice is filed in the County Clerk's Office, no docket number has been assigned for further control.

In order to standardize procedures throughout the State, all involuntary civil commitment cases shall be handled in the manner described below.

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

1. DOCKETING

It shall be the responsibility of the Assignment Judge, either personally or through his Trial Court Administrator, to generally supervise the docketing of all involuntary civil commitment proceedings.

Assignment Judges shall arrange with all hospital facilities in their respective vicinages, so that within 72 hours of accepting a person for treatment, they will have forwarded written notification of this acceptance to the following: the County Clerk; the County Adjuster; the patient; and the patient's nearest relative. The Department of Institutions and Agencies will be contacting all state-run facilities directing them to forward notification in the prescribed manner.

Upon receipt of the above notification, it shall be the obligation of the County Clerk to docket the matter in the County Court. All such proceedings shall be docketed according to county, and in the following manner:

County	*Code*	*Case Number*	*Year Committed*
Atlantic	ATCC	1	74
Bergen	BECC	1	74
Burlington	BUCC	1	74
Camden	CACC	1	74
Cape May	CMCC	1	74
Cumberland	CUCC	1	74

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

County	*Code*	*Case Number*	*Year Committed*
Essex	ESCC	1	74
Gloucester	GLCC	1	74
Hudson	HDCC	1	74
Hunterdon	HNCC	1	74
Mercer	MECC	1	74
Middlesex	MICC	1	74
Monmouth	MNCC	1	74
Morris	MRCC	1	74
Ocean	OCCC	1	74
Passaic	PACC	1	74
Salem	SACC	1	74
Somerset	SOCC	1	74
Sussex	SUCC	1	74
Union	UNCC	1	74
Warren	WACC	1	74

Consequently, "ATCC 1-74" would refer to the first civil commitment case docketed in Atlantic County in the calendar year 1974.[1]

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[1] Cases shall be docketed on a calendar year, rather than court year, basis. This conforms with the practice now prevalent in the county courts.

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

2. Assignment of Cases

Assignment Judges shall be given full discretion to assign civil commitment cases.

3. Scheduling of Cases

It shall be the responsibility of the County Clerk to assure that civil commitment hearings on the final order are held within 20 days from the date of initial commitment.

4. Written Notification of Hearing

It shall be the responsibility of the County Clerk to forward written notification of the time and place of the final hearing to the following: the County Adjuster; any assigned or retained counsel for the patient; the patient's nearest relative; and the plaintiff. Written notification shall be served personally upon the patient in accordance with N.J.S.A. 30:4-41.

In all instances mentioned above, written notification shall be transmitted no later than 5 days prior to the date of the hearing.

5. Adjournment Policy

It shall be the responsibility of the Assignment Judge to effectuate either a judgment of commitment or release of the patient as expeditiously as possible; therefore, in

Hughes, Richard J., Chief Justice of the Supreme Court of New Jersey, Memorandum No. 4-74, dated November 12, 1974

the absence of extraordinary circumstances there shall be no more than one adjournment, which shall only be granted for good cause shown, and the duration of which should not exceed 10 days. If more than one adjournment is granted, a copy of the Order Granting Adjournment, with reasons therefore, shall be forwarded to the Division of Civil Practice, Administrative Office of the Courts, attention Cynthia Jacob.

6. Change in Patient's Status

Assignment Judges shall arrange with all hospital facilities in their respective vicinages to have the medical director or chief of service of said hospitals forward timely notification (which shall be construed as no less than 72 hours if a court hearing has been scheduled) of any substantive change in status to the following: the County Clerk; the County Adjuster; any assigned or retained counsel who may have represented the patient at the last review; the patient's nearest relative; and the plaintiff. Substantive change shall include, but not be limited to: death; discharge; transfer; unauthorized departure; conditional release and return therefrom.

7. Periodic Review

a. It shall be the responsibility of the Assignment Judge to supervise the periodic review of all persons who are now, or may hereafter become, involuntarily committed in their vicinage. For such purposes, docket numbers shall be assigned in the manner described above,

with the last two digits reflecting the calendar year of initial commitment.

For all cases initiated after the effective date of this order, the following schedule shall be adopted:

1. A review of the proceedings 6 months after the date of final commitment.
2. A review of the proceedings 12 months after the date of final commitment.
3. A review of the proceedings 18 months after the date of final commitment.
4. A review of the proceedings 30 months after the date of final commitment.
5. A review of the proceedings every two years thereafter.

b. In all cases in which the patient had already been committed prior to the effective date of this order, the following schedule shall be adopted:

1. All patients committed 10 years or more shall have their cases docketed and reviewed by March 1, 1975 with a further review every 2 years from the date of the last review.
2. All patients committed 5-10 years shall have their cases docketed and reviewed by June 1, 1975, with a further review every 2 years from the date of the last review.
3. All patients committed 30 months to 5 years shall have their cases docketed and reviewed by September 1, 1975, with a further review every 2 years from the date of the last review.

4. All patients committed less than 30 months shall be reviewed in accordance with paragraph (a) of this section.[2]

It shall be the obligation of the County Clerk to assure that proper notification of the review shall be given to: the County Adjuster; the executive director or chief of service of the hospital in which the patient is confined; the patient; any assigned or retained counsel for the patient; the patient's nearest relative; and the plaintiff.

Unless requested by any of the parties mentioned in the preceding paragraph, it shall remain within the court's discretion whether to accomplish the review summarily or by means of a plenary hearing; however, if specifically requested, a hearing shall be scheduled.

8. Patient's Right to Appear

It shall be the responsibility of the Assignment Judge to assure that in all instances in which a hearing has been scheduled, that the patient be given every opportunity to appear. If the medical director or chief of service of the mental hospital feels that in his expert opinion it would

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[2] Officials at the Department of Institutions and Agencies have assured us that they presently are preparing an internal review of each patient's status on a semi-annual basis. Accordingly, there will be no administrative burden placed upon the institutions themselves in complying with this section of the Directive.

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be prejudicial to the health of the patient, or unsafe to produce the patient at the inquiry, then it shall be the obligation of the medical director or chief of service to certify in writing to the court his expert opinion concerning the patient's inability to appear, setting forth the facts supporting his conclusion. The hearing judge shall evaluate any certification submitted and determine whether the personal appearance of the patient is feasible. (See N.J.S.A. 30:4-41).

The policy and procedures set forth in this memorandum shall take effect immediately.

cc: County Counsels
County Adjusters
Department of Institutions and Agencies

Supreme Court, U. S.
FILED
SEP 21 1977
MICHAEL RODAK, JR., CLERK

No. 76-1600

IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

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v.

J. L. AND J. R., Minors, individually and as representatives of a class of persons similarly situated,

Appellees.

On Appeal from the United States District Court for the Middle District of Georgia

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BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. AND J. R., Minors, individually and as representatives of a class of persons similarly situated,

Appellees.

On Appeal from the United States District Court for the Middle District of Georgia

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BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

INTEREST OF AMICUS CURIAE

The American Bar Association is a national membership organization of the legal profession. It counts as

members more than 220,000 lawyers from all states and has, since 1944, maintained an active interest in the field of mental disability law.[1] This interest was intensified in 1973 when the Board of Governors of the American Bar Association established a Commission on the Mentally Disabled, a 17-member interdisciplinary body charged with promoting effective legal assistance to the mentally disabled, and with recommending and implementing programs designed to correct pervasive deficiencies in the nation's mental disability system. Since its inception, the Commission on the Mentally Disabled has focused its efforts toward, *inter alia*: mobilizing, activating, and awarding grants to local and state bar associations to encourage legal representation of the mentally disabled (including appropriate substantive technical assistance); establishing and publishing the *Mental Disability Law Reporter* (hereafter MDLR), an interdisciplinary journal which reports significant developments in the mental disability law field; operating a model in-house patient advocacy project at Norristown State Hospital (Pennsylvania); and developing model legislation to secure rights and services for the developmentally disabled.

The Association has taken the lead in establishing standards for the administration of justice, such as its Standards for the Administration of Criminal Justice and its Standards Relating to Trial Courts (see part 2B, *infra*). The Association has also recently completed a 23 volume tentative draft of juvenile justice standards.

[1] The Association established a Special Committee on the Rights of the Mentally Ill 33 years ago; this committee's recommendations led ultimately to the publication of a number of path-breaking studies by the American Bar Foundation, created by the Association in 1952. See Lindman & McIntyre, *The Mentally Disabled and the Law* (1961); Rock, Jacobson, & Janopaul, *Hospitalization and Discharge of the Mentally Ill* (1968); Matthews, *Mental Disability and the Criminal Law* (1970); Brakel & Rock, *The Mentally Disabled and the Law* (rev. ed. 1971).

Thus, the Association is uniquely experienced and interested in the question now before the Court.

With due consideration of the extended factual legal analysis offered in the briefs of the parties and other *amici*, the Association, with the written consent of the parties,[2] sets forth its views herein on the important question of whether, and to what extent, the Constitution requires procedural safeguards for minors facing civil commitment on the basis of alleged mental disability.

QUESTION PRESENTED BY AMICUS

Whether the due process clause of the Fourteenth Amendment applies to the nominally voluntary but in fact involuntary civil commitment of children on the basis of alleged mental disability, and if so, whether due process requires substantially the same procedural protections for such children as it does for adults?

STATEMENT OF THE CASE

On October 10, 1975, J. L. and J. R., patients in Georgia's Central State Hospital at Milledgeville, filed this class action pursuant to 28 U.S.C. § 1343(3) and 42 U.S.C. § 1983 in the United States District Court for the Middle District of Georgia. A three-judge court was sought and convened pursuant to 28 U.S.C. §§ 2281 and 2284. The action was brought against the Commissioner of the Department of Human Resources, the Director of the Division of Mental Health, and the Chief Medical Officer of Central State Hospital on behalf of all mentally ill children (younger than 18 years of age) indefinitely admitted or committed to mental institutions under Ga. Code Ann. § 88-503.1(a).

[2] A copy of the joint letter indicating the parties' consent has been filed with the Clerk of the Court.

The minor plaintiffs alleged that the Georgia statutory procedure constituted a denial of due process of law under the Fourteenth Amendment to the United States Constitution. The challenged Georgia statute provides that children may be "voluntarily" institutionalized for extended care and treatment without opportunity for a hearing or assistance of counsel, upon a parent's or guardian's application, and the facility superintendent's finding that the child has "evidence of mental illness and . . . [is] suitable for treatment." Admission for observation and diagnosis requires merely parental application.

On February 26, 1976, the District Court ruled on due process grounds that the voluntary admission and commitment procedures of Ga. Code Ann. § 88-503.1(a) were unconstitutional as applied to children under 18 years of age. *J. L. and J. R.* v. *Parham*, 412 F. Supp. 112, 139 (M.D. Ga. 1976). Central to the court's holding was its determination that due process "necessarily includes procedural safeguards to see that even parents do not use the power to indefinitely hospitalize children in an arbitrary manner." 412 F. Supp. at 138.

The District Court specifically rejected defendants' argument that due process protections should not apply because the state is acting as *parens patriae* and not as an adversary in the admission/commitment of children (412 F.Supp. at 137-38), and because the admission/commitment proceedings are civil, not criminal, in nature. 412 F.Supp. at 137. The court held that defendants' reasoning ignored the fact that the child in question is not merely bodily restrained, but is denied the freedom "of an ordinary, every-day child in these United States of America" to be "a normal child in a normal household cared for by normal parents"; ignores the possibility of social ostracism and severe emotional and psychic harm resulting from commitment; and ignores the fact that some parents abuse their parental authority

by abandoning their children to the state under the guise of a mental hospital admission. 412 F.Supp. at 136-138.

The procedural regularity called for by due process, the court stressed, is flexible and such as the particular situation demands, and traditionally includes "at least the right after notice to be heard before an impartial tribunal." 412 F.Supp. at 137. The District Court ruled however, that the statute supplied "absolutely no due process" (412 F.Supp. at 139), and therefore violated the Fourteenth Amendment. It then ordered defendants either "to commence [as to every child under eighteen years of age in their custody] proceedings under Georgia's Juvenile Court Act or other mental health laws not found unconstitutional" or else "to completely remove the child from the custody of the defendants" (412 F.Supp. at 140), and permanently enjoined and restrained defendants from further detaining children under 18 years of age under the statute. *Id.*

While the court did not enumerate specific procedural guarantees, it did endorse existing Georgia juvenile court procedures[3] which require that any child alleged to be in need of treatment or commitment as mentally ill or mentally retarded be provided notice of a hearing, right to counsel (including appointed counsel where undue financial hardship exists), and recordation of the hearing.

The defendants appealed the judgment of the District Court to this Court pursuant to 28 U.S.C. § 1253, and made application for a stay pending appeal. A stay was denied by the trial court, but was subsequently granted

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[3] 1971 Ga. Laws 709, Ga. Juvenile Court Code Title 24A provides that the juvenile courts "shall have exclusive original jurisdiction over juvenile matters and shall be the sole court for initiating action: (1) Concerning any child . . . alleged to be in need of treatment or commitment as a mentally ill or mentally retarded child. . . ." 412 F.Supp. at 131. Subsequent to the decision below, the Georgia Assembly recited recognition of the juvenile courts' primary jurisdiction. See footnote 17, *infra*.

by this Court on April 5, 1976. Probable jurisdiction was noted by this Court on May 31, 1977.

SUMMARY OF ARGUMENT

Civil commitment of an individual on grounds of alleged mental illness is a constitutionally significant deprivation of personal liberty which carries with it serious adverse consequences and disabilities. Such deprivations and disabilities may not constitutionally be imposed without adequate procedural safeguards where the commitment of the individual is involuntary, in fact or in law. Fact finding procedures are particularly important where, as here, the risk of error is substantial, and where, as here, identification of appropriate less restrictive alternatives may obviate the need for commitment to a mental institution.

The asserted interest of the state in providing treatment to mentally disabled juveniles and in preserving the family unit does not justify a substantially different or less stringent application of the due process clause when committing juveniles on mental disability grounds than when committing adults on such grounds. While parents, of course, can and should be involved in any decision to institutionalize a child, it cannot be assumed in every case that the parent is acting in the best interest of the child. Thus the final commitment decision should be made, pursuant to appropriate procedures, by an objective and unbiased tribunal.

ARGUMENT

1. Placement in a Mental Institution Is a Constitutionally Significant Deprivation of Liberty and Carries With It Other Serious and Important Adverse Consequences.

Loss of liberty. Commitment to a mental institution necessarily entails a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972), and inevitably affects "fundamental rights." *Baxstrom* v. *Herold*, 383 U.S. 107, 113 (1966). Perhaps the most basic aspect of constitutional liberty is the right to be free from unwarranted physical confinement. *Arnett* v. *Kennedy*, 416 U.S. 134, 157 (1974). Avoiding extreme restrictions on personal liberty such as those imposed by involuntary civil commitment has been held by this Court to be an interest of "transcending value." *In re Winship*, 397 U.S. 358, 364 (1970).

Although there may be differences between the involuntary commitment of an adult, where the state may assume a more active role, and the commitment of a minor, in which the parents are more directly involved,[4]

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[4] As of 1976 the following states had voluntary commitment statutes allowing parents or guardians to commit minors: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada (due process rights, including right to counsel and a hearing, are not forfeited when children are admitted by their parents), New Jersey (modified by state Supreme Court rule November 12, 1974), New Mexico (repealed and replaced by H.R. 472 (April 8, 1977)), New York (minor may effect his own release), North Carolina (statute declared unconstitutional in *In re Long*, 25 N.C. App. 702, 214 S.E.2d 626 (1975)), North Dakota, Ohio, Oklahoma, Oregon, South Carolina (minor under age 16 may apply for his own release), Tennessee (child may apply for his own release), Utah, Virginia, Washington (consent of minor over age 13 required), West Virginia (minor age 12 and over may apply for his own release), Wisconsin (consent of minor over age 13 required), and Wyoming.

[Footnote continued on page 8]

the results in terms of physical and emotional deprivations are, if different in kind, at least equal in impact and severity.[5] Adults and children alike are deprived of their basic right to personal liberty; all are removed from their homes, communities, and normal daily activities, and are subjected to the custody and control of persons (usually agents of the state) not of their own choosing.

The commitment of a minor to an institution is a traumatizing disruption of his life which cannot fail to have far-reaching consequences. A committed child is separated from a known environment of family, friends, and school and plunged into a frightening, unfamiliar world. See *In re Gault*, 387 U.S. 1, 27 (1967). As one expert witness testified below:

> [I]t seems to [me] the hospitalization . . . [is] really . . . like a sentence of death [A. 803] . . . . I think that this is one of the frightening aspects of hospitalization, that once the child is put behind doors, he is forgotten, . . . and that trauma at that point is really followed by the trauma that perhaps nobody else will care for him, and no matter how therapeutic the hospital may be, some link to the outside world still would be very important to have. A. 810.

[4] [Continued]

The following states had no age distinction in their voluntary commitment statutes: Iowa, Louisiana, Idaho (but if a parent admits a minor, consent of the parent is required for release), Minnesota, Nebraska, and Rhode Island. A child's consent is required in Delaware, Maine, Montana, and Texas. Alabama considers commitment of a child by his parents to be involuntary commitment. New Hampshire and Vermont specifically exclude children from voluntary commitment precedures. South Dakota has no voluntary commitment statute. "Due Process Limitations on Parental Rights to Commit Children to Mental Institutions," 48 U. Colo. L. Rev. 235, 236 (1977).

[5] Parental or familial involvement is not uncommon in the civil commitment of adults. See *O'Connor* v. *Donaldson*, 422 U.S. 563, 565 (1975), where the petitioner was committed at the instance of his parents and spent 15 years in the Florida State Hospital for the mentally ill.

Testimony in this case further established the difficulty of subsequent reintegration of the child into his once familiar world (A. 176-177). See also, A. 904; "Minors' Right to Due Process: Does it Extend to Commitment to Mental Institutions?" 52 Notre Dame Law. 136, 140 (1976). The feeling of abandonment occasioned by institutionalization is especially intense for younger children who are adversely affected by such feelings sooner than other children. Goldstein, Solnit & Freud, *Beyond the Best Interest of the Child*, 40-49 (1973). Institutionalization may also retard the normal intellectual and emotional development of a child.[6] Thus there is no reason to assume that the institutionalization decision, and the fact of institutionalization, are of any less consequence for minors than for adults (A. 177-178). If anything, the opposite appears to be the case.

Involuntary treatment. In addition to the deprivation of liberty inherent in an indefinite commitment, such commitment carries with it the risk of physically intrusive treatment which, especially if unwarranted, may violate the committed individual's right to bodily integrity. See *Schmerber* v. *California*, 384 U.S. 757, 772 (1966); *Rochin* v. *California*, 342 U.S. 165 (1952). Such treatment modalities may include forced administration of psychotropic medication, see *Winters* v. *Miller*, 446 F.2d 65 (2nd Cir. 1971), *cert. den.* 404 U.S. 985 (1971); *Scott* v. *Plante*, 532 F. 2d 939 (3rd Cir. 1976); *Souder* v. *McGuire*, 423 F.Supp. 830 (M.D. Pa. 1976); aversive conditioning, see *Knecht* v. *Gillman*, 488 F.2d 1136 (8th Cir. 1973); *Mackey* v. *Procunier*, 477 F.2d 877 (9th Cir. 1973); *Wyatt* v. *Hardin*, No. 3195-N (M.D. Ala.,

[6] Glenn, "The Least Restrictive Alternative in Residential Care and the Principle of Normalization," in *The Mentally Retarded Citizen and the Law*, at 499-501 (1976); Hobbs (ed.), *Issues in the Classification of Children*, at 135, 142-143 (1975); Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's*, at 321-324, 330-331 (1970); Provence & Lipton, *Infants in Institutions*, at 19 (1962).

February 28, 1975, June 26, 1975, and July 1, 1975), 1 MDLR 55; convulsive therapy, see *Wyatt* v. *Hardin*, *supra*, *Price* v. *Sheppard*, 239 N.W. 2d 905 (Minn. 1976), 1 MDLR 120; *Nelson* v. *Hudspeth*, C.A. No. J75-40(R) (S.D. Miss., May 16, 1977); and even psychosurgery, see *Kaimowitz* v. *Michigan Department of Mental Health*, No. 73-19434-AW (Cir. Ct. Wayne County, Mich., July 10, 1973), 1 MDLR 147.[7]

Of course, not every institutionalized minor will be subjected to hazardous or intrusive procedures, but the fact is that institutionalization, to some degree, confers upon the state the power to impose treatment upon an institutionalized individual—treatment which by its very nature may involve "impermissible tinkering with mental processes," *Mackey* v. *Procunier*, *supra*, 477 F.2d at 877, or a violation of the right of privacy. See *Roe* v. *Wade*, 410 U.S. 113 (1973); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965). Obviously, no one, especially a child, should be exposed to the risk of such treatment without a prior determination that it is warranted and appropriate.

Stigmatization. As courts have noted,[8] institutionalization on mental disability grounds almost inevitably stigmatizes the individuals involved in a way that adversely affects them the rest of their lives. Such stigmatization may result in or be accompanied by the scorn or obloquy of one's peers, loss of employment possibilities and education benefits, and other civil disabilities (A. 784).[9] In

[7] See generally Friedman, "Legal Regulation of Applied Behavioral Analysis in Mental Institutions and Prisons," 17 Ariz. L. Rev. 39 (1975).

[8] E.g., *Lessard* v. *Schmidt*, 349 F.Supp. 1078, 1088-90 (E.D. Wis. 1972), *vacated on procedural grounds* 414 U.S. 473 (1974), *on remand* 379 F.Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds* 421 U.S. 957 (1975), *on remand* 413 F.Supp. 1318 (E.D. Wis. 1976); *In re Roger S.*, Crim. 19558, slip op. at 7 (Cal., July 18, 1977).

[9] Cf. Comment, "Developments in the Law—Civil Commitment of the Mentally Ill," 87 Harv. L. Rev. 1190, 1198-1201 (1974); *Goss*

these circumstances, see *Paul* v. *Davis*, 424 U.S. 693, 701-705 (1976), an individual's interest in his good reputation is a liberty (or property) interest entitled to constitutional protection. *Board of Regents* v. *Roth*, 408 U.S. 564, 573 (1972); *Wisconsin* v. *Constantineau*, 400 U.S. 433 (1971).

Possibility of inhumane or inadequate treatment. It is unfortunate but true that many of our nation's public mental institutions do not provide minimally adequate habilitative or rehabilitative programming, but in fact may subject their patients or residents to inhumane and unsafe living conditions, destructive psychological pressures, and even physical abuse by other patients or residents or by staff members, all in violation of constitutional guarantees. As in *In re Gault*, *supra*, 387 U.S. at 15-21, this Court should take note of such possibility, which has been well documented by lower Federal courts,[10]

v. *Lopez*, 419 U.S. 565, 579 (1975) "[Charges of misconduct] could seriously damage the students' standing with their fellow pupils and teachers as well as interfere with later opportunities for higher education and employment [footnote omitted]." *In re Ballay*, 482 F.2d 648, 667-669 (D.C. Cir. 1973). *In re Coleman*, Cir. Ct. No. 76-639-949 AV (Cir. Ct. Wayne County, Mich., Feb. 23, 1977). See also, "Minors' Right to Due Process," *supra*, 52 Notre Dame Law. at 140.

[10] E.g., *O'Connor* v. *Donaldson*, *supra*; *Wheeler* v. *Glass*, 473 F.2d 983 (7th Cir. 1973); *Davis* v. *Watkins*, 384 F.Supp. 1196 (N.D. Ohio 1974); *Welsch* v. *Likins*, 373 F.Supp. 487 (D. Minn. 1974), *enforced* No. 4-72-Civ. 451 (D. Minn., October 1, 1974), 1 MDLR 193, *aff'd in part* Nos. 76-1473 and 76-1797 (8th Cir., March 9, 1977), 1 MDLR 334; *New York State Association for Retarded Children and Parisi* v. *Rockefeller*, 357 F.Supp. 752 (E.D.N.Y. 1973), *modified* No. 72-C-356/357 (E.D.N.Y., May 23, 1973), *order on consent sub nom. New York State Association for Retarded Children and Parisi* v. *Carey*, No. 72-C-356/357 (E.D.N.Y., April 30, 1975), *approved* 393 F.Supp. 715 (E.D.N.Y. 1975), 1 MDLR 58; *Romeo Youngberg*, C.A. No. 76-3429 (E.D. Pa., June 6, 1977); *Vanderzeil* v. *Hudspeth*, C.A. No. J76-262(R) (S.D. Miss., Feb. 11, 1977); *Horacek* v. *Exon*, 354 F.Supp. 71 (D. Neb. 1973), *order on consent* No. 72-L-299 (D. Neb., October 31, 1975); *Wyatt* v. *Stick-*

in determining the procedural protections which should attend the commitment of anyone, especially a child, to a mental institution. In those jurisdictions where substandard conditions exist, the consequences of erroneous institutionalization decisions are especially grave.

As with all the other types of deprivations and adverse consequences cited in this part, no reason appears why such infringments of constitutionally protected rights are of any less consequence in the case of children than they are in the case of adults (A. 177-178).

2. Confinement in a Mental Institution Cannot Be Constitutionally Imposed by the State or Under the Authority of State Law Without Adequate Procedural Safeguards.

This Court has repeatedly determined that prior to a deprivation of a constitutionally protected interest, the due process clause demands that procedures be established to determine the necessity and legal justification for the proposed deprivation. This Court has adopted a flexible approach by tailoring the procedural requirements according to the weight of the competing individual and governmental or societal interests at stake. See, *e.g.*, *Wolff* v. *McDonnell*, 418 U.S. 539 (1974); *Morrissey* v. *Brewer*, 408 U.S. 471, 481-90 (1972); *Bell* v. *Burson*, 402 U.S. 535, 539-42 (1971); *Boddie* v. *Connecticut*, 401 U.S. 371 (1971); *Goldberg* v. *Kelly*, 397 U.S. 254, 263-71 (1970); *Cafeteria Workers Union* v. *McElroy*, 367 U.S. 886, 895 (1961).[11]

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ney, 325 F.Supp. 781 (M.D. Ala. 1971), 334 F.Supp. 1341 (M.D. Ala. 1971), 344 F.Supp. 373 and 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974). *Cf. Gruenberg*, "The Social Breakdown Syndrome—Some Origins," 123 Am. J. Psychiatry 12 (1967); Barton, *Institutional Neurosis* (2d ed. 1966); Goffman, *Asylums* (1961).

[11] Defendants in their brief rely heavily upon two recent decisions of this Court to establish that Georgia's procedures comport with due process. See defendant's brief's pp. 28-43. However, both de-

While this Court has not ruled directly on the procedural requirements for civil mental disability commitments, it has mandated strict procedural safeguards in the analogous areas of quasi-criminal commitments, *Specht* v. *Patterson*, 386 U.S. 605 (1967), and institu-

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cisions, *Ingraham* v. *Wright*, —— U.S. ——, 97 S.Ct. 1401 (1977), and *Smith* v. *Organization of Foster Families for Equality and Reform*, —— U.S. ——, 97 S.Ct. 2094 (1977) (hereinafter cited as *OFFER*), are clearly distinguishable from the present case.

In *OFFER*, this Court, facing difficult and complex questions concerning the constitutional adequacy of the procedure protecting foster parents from removal of their foster children, found the New York system to comport with due process. Unlike the Georgia commitment procedures, the New York procedures included a 10-day advance notice of removal; an opportunity for a conference; an opportunity for judicial review; and in certain cases, a full administrative hearing with the right to judicial review. These procedures clearly offer more protection than the Georgia procedures, under which the named plaintiffs herein were institutionalized for six years without any hearing whatsoever.

Further, the nature of the interest in *OFFER* differs from that in the instant case. As this Court noted in *OFFER*, "the distinctive features of foster care are first, 'that it is care in a *family*, it is noninstitutional substitute care,' and second 'that it is for a *planned* period—either temporary or extended'" (97 S.Ct. 2099) (emphasis in original). Commitment of a child in Georgia to a mental hospital results in care in an *institutional* setting for an *indefinite* period. Thus, the two situations are not comparable.

In *Ingraham* v. *Wright*, this Court held that the infliction of reasonable corporal punishment on public school children by teachers could be accomplished without first resorting to an administrative hearing. This case is also distinguishable from the case at hand. First, there is a significant constitutional difference between paddling a child, and indefinitely committing him to a mental hospital.

Furthermore, as this Court noted in *Ingraham*:

> Were it not for the common law privilege permitting teachers to inflict reasonable corporal punishment on children in their care, and the availability of the traditional remedies for abuse, the case for requiring advanced procedural safeguards would be strong indeed. 97 S.Ct. 1414.

No readily apparent authority reveals an analogous common law privilege allowing a parent to commit a child to a state mental hospital. See, Panneton, "Children, Commitment and Consent: A

tionalization of juvenile delinquents, *e.g.*, *In re Winship*, *supra*; *In re Gault*, *supra*. Indeed, the Chief Justice noted in his concurring opinion in *O'Connor* v. *Donaldson*, *supra*, 422 U.S at 580, that

> [t]here can be no doubt that involuntary commitment to a mental institution, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law. . . . Commitment must be justified on the basis of legitimate state interest, and the reason for committing a particular individual must be established in an appropriate proceeding. (Citations omitted.)

Numerous lower Federal courts, relying in part on the above-cited cases, have struck down civil commitment statutes found to be deficient in procedural safeguards. *Stamus* v. *Leonhardt*, 414 F.Supp. 439 (S.D. Iowa 1976); *Suzuki* v. *Quisenberry*, 411 F.Supp. 1113 (D. Hawaii 1976), 1 MDLR 46; *Goldy* v. *Beal*, 429 F.Supp. 640 (M.D. Pa. 1976), 1 MDLR 137; *Doremus* v. *Farrell*, 407 F.Supp. 509 (D. Neb. 1975); *Kendall* v. *True*, 391 F.Supp. 413 (W.D. Ky. 1975); *Lynch* v. *Baxley*, 386 F.Supp. 378 (M.D. Ala. 1974); *Bell* v. *Wayne County*, 384 F.Supp. 1085 (E.D. Mich. 1974); *Lessard* v. *Schmidt*, *supra*; *Dixon* v. *Attorney General of the Commonwealth of Pennsylvania*, 325 F.Supp. 966 (M.D. Pa. 1971). *Cf. State ex rel. Hawks* v. *Lazaro*, 202 S.E. 2d 109 (W. Va. 1974); *Denton* v. *Commonwealth*, 383 S.W. 2d 681 (Ky. 1964).

Constitutional Crisis," 10 Family L.Q. 295 (1977). Nor is an analogous remedy for abuse available to the inappropriately committed child (A. 789-790).

Thus, neither *OFFER* nor *Ingraham* diminish the district court's finding that children are entitled to due process protections when faced with the possibility of the grievous loss of liberty involved in an indefinite commitment to a state mental institution.

Indeed, many courts other than the District Court in the instant case have similarly held due process requirements to be specifically applicable to mental disability commitments of children. *Bartley* v. *Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), *rev'd on other grounds* —— U.S. ——, 97 S.Ct. 1709 (1977); *In re Roger S.*, *supra*; *Saville* v. *Treadway*, 404 F.Supp. 430 (M.D. Tenn. 1974); *Kidd* v. *Schmidt*, 399 F.Supp. 301 (E.D. Wis. 1975). *Cf. Pima County Public Fiduciary* v. *Superior Court*, 546 P.2d 354 (Ariz. Ct. App. 1976).

A. The District Court Properly Recognized That Juveniles Facing Confinement in a Mental Institution are Entitled to Adequate Notice and to Counsel.

The lower court cases have concluded, in particular, that the requirements of due process include the right to meaningful notice given sufficiently in advance of any proceedings so as to apprise the individual of the grounds for the proposed commitment along with the procedural and substantive rights afforded him. *Suzuki* v. *Quisenberry*, *supra*, 411 F.Supp. at 1127; *Doremus* v. *Farrell*, *supra*, 407 F.Supp. at 515; *Lynch* v. *Baxley*, *supra*, 386 F.Supp. at 388; *Bell* v. *Wayne County*, *supra*, 384 F.Supp. at 1092; *Lessard* v. *Schmidt*, *supra*, 349 F.Supp. at 1092. In addition, lower court opinions have uniformly held that an individual faced with the prospect of involuntary commitment for an indefinite period is entitled to the effective assistance of counsel, including the appointment of counsel if the individual cannot afford retained counsel, and that counsel must be made available far enough in advance of any hearing to provide adequate opportunity for preparation. *Suzuki* v. *Quisenberry*, *supra*, 411 F. Supp. at 1129; *Doremus* v. *Farrell*, *supra*, 407 F.Supp. at 515; *Lynch* v. *Baxley*, *supra*, 386 F.Supp. at 389; *Bell* v. *Wayne County*, *supra*, 384 F.Supp. at 1093-94; *Lessard* v. *Schmidt*, *supra*, 349 F.Supp. at 1097-98. *Cf. Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968).

In the instant case, the court below ordered due process proceedings to be commenced under statutory provisions not found to be unconstitutional, specifically mentioning the Georgia Juvenile Court Act which confers jurisdiction over any child "alleged to be in need of treatment or commitment as a mentally ill or mentally retarded child. . . ." 412 F.Supp. at 131. That act explicitly provides for notice of a hearing, right to counsel or appointed counsel (where financial hardship exists), and a recorded, nonjury hearing. The unique aspects of a juvenile mental disability commitment, where the child may in certain situations be more subject to implicit or explicit coercion (A. 903) and less likely to appreciate or comprehend the nature of the proceedings, are taken into account by ensuring these rights. Indeed, consultation with counsel may, in some cases, lead to dispensing with other formal procedures and would protect a child from unwarranted waiver of his rights.[12]

Supplementing the legal authority for the appointment of counsel[13] was expert testimony below which agreed that counsel played a beneficial role in the proceedings for all involved. The testimony indicated that the advocate for the child is perceived by the child as representing his interests in the commitment proceedings (A. 180). Despite assurances to the contrary from parents or the psychiatrists, the child is likely to perceive their role as adversarial. Appointment of counsel for the child thus

[12] Of course, it should be recognized that a hearing may not be held in every case. The experience of the New Jersey Department of the Public Advocate indicates that often juvenile commitment cases are concluded before a hearing is held. See Sec. I(c), Brief of Amicus, New Jersey Department of the Public Advocate.

[13] See also, "Minors' Right to Due Process," *supra*, 52 Notre Dame Law. at 142, 144, which advocates "[t]he appointment of *medical and legal* advocates . . . [as] an appropriate means of ensuring that the child's interests are given full judicial consideration" (at 144, emphasis added).

decreases the chance that the child will feel "railroaded" and makes him more amenable to treatment if commitment is ordered (A. 180-181, 183).

B. The Right to Counsel, in Particular, Has Been Emphasized by the American Bar Association as a Matter of Sound Judicial Administration.

Appointment of counsel along the lines of the lower court's order has been incorporated into the Standards Relating to Trial Courts drafted by the American Bar Association Commission on Standards of Judicial Administration and adopted by the Association's House of Delegates at its mid-year meeting in February, 1976. Section 2.72 of the trial court standards,[14] which sets forth the procedural requirements for civil commitment proceedings, specifically provides that persons subject to such proceedings are entitled to the assistance of counsel as provided in Section 2.20. That section, in addition to permitting a litigant to employ counsel in any judicial proceeding, requires that counsel be appointed for persons unable to afford their own counsel when they are "subject to a civil proceeding in which the result may be detention for a period longer than 72 hours."

In its commentary with regard to Section 2.20, the Commission on Standards of Judicial Administration noted:

> In addition to representation in criminal cases, counsel should be appointed to represent any person who is the subject of a civil proceeding in which the result may be his physical commitment or detention for any period beyond brief emergency detention. Such proceedings include commitment of the mentally ill, mentally deficient, narcotics addicts, alcoholics, "defective delinquents," "sexual psychopaths," and similarly defined persons. The distinc-

[14] The complete text of Section 2.72 and accompanying Commentary are attached as the appendix to this brief.

> tion between these procedures and criminal prosecution is often more theoretical than real, for the state plays an adversary role, as in criminal cases, and the consequence of adjudication may be long confinement—sometimes for an indefinite period—in an institution where the conditions of custody to a greater or lesser degree resemble a prison. A like necessity for counsel exists in deportation and contempt proceedings. Where the individual involved is mentally disturbed or deficient, or lacks facility in speaking English, the need for counsel is all the more urgent because the person cannot speak effectively for himself.

Clearly, the commitment of a minor falls within the type of situation contemplated by Standard 2.20.[15]

As previously developed, the court below implicitly required procedural rights other than counsel for children facing commitment, all of which find support in some or all of the authorities supporting *amicus*' arguments herein.[16] *Amicus* would point out also that Section 2.72 of the Association's trial court standards and the procedural safeguards required by the court below (i.e. Ga. Juvenile Court Code Title 24A) are very similar, in that both contemplate the right to notice, counsel, and personal presence at such hearings, along with the rights of con-

[15] The critical role of counsel for children is also discussed at length in draft standards relating to the juvenile justice system which were recently published by the Juvenile Justice Standards Project. The Project, a joint venture of the Institute of Judicial Administration and the American Bar Association, has produced a draft twenty-three volume series covering the entire field of juvenile justice administration. At present, the standards have not been approved by the American Bar Association, but are scheduled to be considered at the Association's 1978 mid-year meeting. IJA-ABA, Standards Relating to Counsel for Private Parties (Tent. Draft, 1977).

[16] The utility of particular procedural safeguards may vary to some extent depending on the age and maturity of the child involved.

frontation, cross-examination, and presenting evidence on one's own behalf.

C. The District Court Was Correct in Finding That the Stricken Georgia Code Provisions for Admission or Commitment of Children Do Not Satisfy the Requirements Enumerated Above.

A plain reading of the Georgia statute here in question, Ga. Code Ann. § 88-503.1(a), demonstrates that it affords children subject to institutionalization none of the procedural protections mandated by the above-cited constitutional decisions or endorsed by the American Bar Association.[17] The fact that the state's custom is to screen

[17] Shortly before this Court noted probable jurisdiction herein, Georgia enacted alternate procedures for admitting minors which are "cumulative and . . . not to be used in lieu of present methods of providing treatment for mentally ill children either under this Title or under Code Chapters 88-4, 88-5, and 88-25, but . . . [are] only to be used in the event that these other methods are not available." Act No. 331 (March 23, 1977).

The alternate statute allows any legal custodian (or physical custodian if the legal custodian cannot be contacted) to initiate voluntary admission of his or her ward (under 17 years of age) to a mental health facility by bringing the ward to an emergency receiving facility for examination. Upon the examining physician's determination that the child is mentally ill or retarded, is in need of immediate medical assistance, and is in need of hospitalization, the child will be admitted to the facility. The statute requires that the child's parents or guardian be notified immediately of such admission, and that a petition be filed in juvenile court by the person seeking the child's hospitalization within 24 hours of such admission. A finding of probable cause at the juvenile court hearing required to be held within three days of the filing of the petition enables the hospital to confine the child until a full hearing on his mental status is held.

The full hearing must be held within ten days of the filing of the petition. Commitment is authorized only if the juvenile court judge, at the final hearing, determines that the child is mentally ill or mentally retarded and is in need of hospitalization. Otherwise, the petition must be dismissed and the child discharged from the facility. The order authorizing commitment is effective for six months, but may be extended. The statute prohibits hospitali-

children at a community mental health center and at the receiving facility does not cure this total lack of due process safeguards.[18] Even assuming that each case is screened by the best-intentioned psychiatrist, inappropriate commitments are possible.

> Psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession. It must be conceded that phychiatrists still experience considerable difficulty in confidently and accurately diagnosing mental illness. *People* v. *Burnick*, 14 Cal. 3d 306, at 326-27, 121 Cal. Rptr. 488, at 501 (1975).

See also *In re Ballay*, *supra*, 482 F.2d at 665; *In re Roger S.*, *supra*, slip op. at 7; Ennis & Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," 62 Calif. L. Rev. 693, 719 (1974); A. 171-172, 173-175, 792-793, 714, 805, 806. See also discussion of reliability of psychiatric judgement at pages 21-24, *infra*.

Expert testimony below corroborated the view that placing sole reliance on a psychiatric diagnosis, without recourse to review by an unbiased tribunal, will not suffice to prevent unnecessary or inappropriate commitments (A. 174-175, 808, 809).

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zation when treatment can be provided most appropriately in a less restrictive setting.

(The enactment also recites the General Assembly's recognition that the Juvenile Court may make disposition of mentally ill/retarded children under Code Section 24A-2601, and recognition that the Juvenile Court has primary jurisdiction over the commitment of juveniles who meet the criteria of Code Chapters 88-4, 88-5, and 88-25.)

[18] Indeed, the testimony of the Director of the Office of Child and Adolescent Mental Health Services, Atlanta Division, indicates not only that such practice is not mandatory (A. 757), but that it can be ignored entirely (A. 757-758). (See also defendants' brief, p. 3.) This same testimony further indicates that even at the state hospital level, no statewide regulations exist (A. 781-783) to ensure that every child receives even a uniformly minimum screening.

D. The Labeling of Juvenile Mental Disability Commitments As Civil (Rather Than Criminal), Benevolent, or Voluntary Does Not Affect the Applicability of the Due Process Clause.

This Court has long avoided the labeling of a particular proceeding as "civil" rather than "criminal" and has repeatedly imposed due process requirements when it was clear that the potential existed for serious deprivation of constitutionally protected interests. E.g., *Breed* v. *Jones*, 421 U.S. 519, 530 (1975); *In re Gault*, *supra*; *Specht* v. *Patterson*, *supra*; *cf. Heryford* v. *Parker*, *supra*, 396 F.2d at 396. The same deprivations threatened in these juvenile and quasi-criminal "civil" cases are present here, and the same reasoning should apply. This Court should affirm the District Court's rejection of the defendants' argument that the benevolent (habilitative or rehabilitative) purpose of juvenile mental disability commitments insulates them from due process requirements. See 412 F.Supp. at 137-138. The statutory characterization of these admissions and commitments as "voluntary" should not mask the fact that they are voluntary on the part of the parent (or other person or agency seeking institutionalization), but not on the part of the child being deprived of his liberty. Thus the requirements of due process should apply.

E. The Imposition of Due Process Protections Upon the Institutionalization Decision Is Necessitated Both by the Risk of Erroneous Psychiatric and Other Judgments and by the Need to Ensure That Less Restrictive Alternatives Are Adequately Explored.

The deprivations and consequences of institutionalization described in the first part of *amicus*' argument would, in themselves, require that institutionalization decisions made by or through the authority of the state be subject to the requirements of the due process clause. The special nature of the admission/commitment decision, however, demands the type of procedural safeguards man-

dated by the District Court for at least two further reasons—the uncertainty of psychiatric (and other) diagnoses, and the need, from both a professional and constitutional standpoint, to place an allegedly mentally disabled person in the least restrictive setting which will meet his treatment needs.

The Chief Justice has recently noted the "uncertainties" of diagnosis and therapy in the "baffling" field of psychiatry, and has observed, correctly, that "the reported cases are replete with evidence of the divergence of medical opinion in this vexing area." *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 579 (Burger, C.J., concurring). This Court has previously remarked upon "the uncertainty of diagnosis in this field and the tentativeness of professional judgment." *Greenwood* v. *United States*, 350 U.S. 366, 375 (1956); *cf.* Ennis & Litwack, *supra*.

An admission/commitment hearing would serve to check this uncertainty. The pendency of a hearing would also dilute the tendency of some psychiatrists to overdiagnose or to err on the side of caution, assuming disease over health. See Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions," 62 Calif. L. Rev. 840, 865 (1974); Rosenhan, "On Being Sane in Insane Places;" 113 Santa Clara L. Rev. 379 (1973). Given the uncertainties in the field of mental disability, and the difficulty in relating psychiatric or psychological diagnoses to legal standards for commitment,[19] proper fact-finding procedures are a practical and constitutional necessity in the civil commitment process.

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[19] Shah, "Dangerousness: Some Definitional, Conceptual, and Public Policy Issues," in *Perspectives in Law and Psychology* (B. Sales ed. 1977); Shah, "Some Interactions of Law and Mental Health in the Handling of Social Deviance," 23 Catholic U.L. Rev. 647 (1974).

Moreover, it is no longer open to serious question that state-imposed deprivation of personal liberty for purposes of mental disability treatment, or any other such incursion on constitutionally protected liberties, must be only to the limited extent necessary to accomplish the legitimate purpose of the deprivation or limitation in question. *Shelton* v. *Tucker*, 364 U.S. 479, 488-490 (1960). Numerous lower Federal courts have recognized the applicability of this "least restrictive alternative" doctrine to commitment and treatment of the mentally disabled. *New York State Association for Retarded Children and Parisi* v. *Carey*, *supra*, Order of April 30, 1975, 1 MDLR 58; *Lynch* v. *Baxley*, *supra*, 386 F.Supp. at 392; *Welsch* v. *Likins*, *supra*, 373 F.Supp. at 501-502; *Lessard* v. *Schmidt*, *supra*, 349 F.Supp. at 1096; *Wyatt* v. *Stickney*, *supra*, 344 F.Supp. at 379, 396; *cf. Dixon* v. *Weinberger*, 405 F.Supp. 974 (D.D.C. 1975),[20] 1 MDLR 12; *Covington* v. *Harris*, 419 F.2d 617 (D.C. Cir. 1969); *Lake* v. *Cameron*, 364 F.2d 657 (D.C. Cir. 1966). Indeed, this Court has specifically applied this rationale to mental disability commitments in *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 575:

> "May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him

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[20] In this case, based on the 1964 Hospitalization of the Mentally Ill Act, 21 D.C. Code §§ 501*ff*., the District Court, in endorsing the least restrictive approach to both commitment and treatment, found, not only that some patients in the District of Columbia mental hospital could fare as well in the community, but also that the treatment needs of 43% of the patients *required* them to be in the community. 405 F.Supp. at 976.

> from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom on their own or with the help of family or friends. See *Shelton* v. *Tucker*, 364 U.S. 479, 488-490."

Expert testimony in this case (A. 180) and the professional literature[21] are in accord with the foregoing legal analysis.[22] Thus, perhaps the most vital function of procedures such as those required by the court below is to prod the parents, professionals, and others involved in the admission/commitment process to avoid unnecessary and inappropriate institutionalization and, if necessary, to invest the resources of other social agencies and the committing tribunal in identifying or creating treatment alternatives which will not unduly limit the personal freedom (or the therapeutic prognosis) of the individual facing commitment.

3. Children Facing Commitment on Mental Disability Grounds are Entitled to Substantially the Same Procedural Protections Afforded Adults Under the Due Process Clause.

As noted above, admission/commitment of children to mental institutions involves at least an equivalent degree of deprivation and risk, and is subject to the same

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[21] Glenn, *supra*, at 499-514; Wolfensberger, *The Principle of Normalization in Human Services* (1972); Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents*, at 55 (1974). This legal and professional consensus is reflected in the Federal Medicaid regulations governing under-21 inpatient psychiatric services (45 C.F.R. § 249.10(b)(16)(iii), 41 F.R. 2198 (January 14, 1976), and institutional care and treatment of the mentally retarded (45 C.F.R. §§ 249.13(a)(2)(iv), 39 F.R. 2220. 2227 (January 17, 1974)).

[22] The Georgia General Assembly has recognized the necessity of the least restrictive alternative in the juvenile commitment context. See footnote 17, *supra*.

possibility of erroneous or inappropriate diagnosis or placement decisions, as the involuntary commitment of adults. In the instant case, the only asserted basis for denying to such children the procedural protections due adults relates to a somewhat vaguely defined state interest in preserving parental authority and family unity. However, the parents' legitimate concerns can be accommodated without vesting in them and state authorities unfettered control over the institutionalization of children. The asserted state interest cannot justify the deprivation of children's personal liberty without due process of law.

A. The Decisions of This Court Indicate That Parental Authority Is Not Without Limits, and That Children, As Well As Adults, Are Entitled to Constitutional Protections.

This Court has been presented with numerous cases involving the issue of the scope and nature of parental authority in the upbringing of their children, and has generally accorded parents great leeway. *Wisconsin* v. *Yoder*, 406 U.S. 205 (1972); *Ginsberg* v. *New York*, 390 U.S. 629 (1968); *Pierce* v. *Society of Sisters*, 268 U.S. 510, 539 (1925); *Meyer* v. *Nebraska*, 262 U.S. 390 (1923). However, as important as the result in *Wisconsin* v. *Yoder*, *supra*, was its carefully circumscribed definition of parents' authority as related to denial of their children's opportunity for a free, public secondary school education. *Id.* at 230-234.[23]

The parental authority recognized by this Court has never been absolute, and where a superseding state interest has been demonstrated, this Court has not hesitated to condone intrusion into the parent-child relation-

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[23] Moreover, *Wisconsin* v. *Yoder* turned on First Amendment freedom of religion questions which have no parallel in the instant case.

ship, primarily in a situation where the child's welfare could be jeopardized:

> But the family itself is not beyond regulation in the public interest. . . . Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways. *Prince* v. *Massachusetts*, 321 U.S. 158, 166 (1944).

At the same time, this Court has recognized that minors are entitled to many of the same constitutional rights and protections that adults enjoy, *Tinker* v. *Des Moines Independent Community School District*, 393 U.S. 503 (1969), particularly with regard to procedural due process. Minors facing the possibility of institutionalization as a result of delinquent behavior have been accorded almost all the procedural safeguards as adult defendants. See *Breed* v. *Jones*, *supra*; *In re Winship*, *supra*; *In re Gault*, *supra*. Due process protections have even been accorded to students facing suspensions from school of ten days or less. *Goss* v. *Lopez*, *supra*.[24] Against this background, it would be anomalous to hold that procedural due process protections should not apply as well to indefinite commitment of minors to mental institutions.

B. This Court's Abortion Decisions Reflect the Proper Balancing of Interests to Be Applied in the Instant Case.

In *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976), and *Bellotti* v. *Baird*, 428 U.S. 132 (1976), this Court was confronted with the question, *inter alia*, of whether parents could constitutionally prevent their minor daughters from obtaining abortions under circumstances in which, pursuant to *Roe* v. *Wade*,

[24] This Court's ruling in *Ingraham* v. *Wright*, *supra*, does not undercut due process requirements in the context of the present case. See footnote 11, *supra*.

supra, adult women would have an absolute right to terminate unwanted pregnancies.

"Constitutional rights," this Court observed, "do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights." *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 74. Given that in some instances, the state's authority to regulate children may be broader than its authority with respect to adults, the Court continued, it is necessary

> to examine whether there is any significant state interest in conditioning an abortion on the consent of a parent or person *in loco parentis* that is not present in the case of an adult.
>
> One suggested interest is the safeguarding of the family unit and of parental authority. [Citation omitted.] It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant. *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 75.

The Court's holding in the *Planned Parenthood* case leads directly to the conclusion that the existence of a conflict between parent and child does not mean the constitutional rights of the child must inevitably give way.

Certainly, a child's interest in avoiding a wrongful, inappropriate, and potentially lifelong commitment to a mental institution is equivalent in gravity and importance to a minor's right to obtain an abortion, and the same balancing of interests is required. So examined, the child's interest in not being improperly institutionalized outweighs the parent's (or guardian's) interest in having absolute (or near-absolute) control over the commitment decision.

Moreover, if the state, *qua* state, cannot institutionalize an individual without proper procedural protections, such authority cannot constitutionally be delegated to a parent or other third party. *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 69.

C. The District Court Properly Accommodated the Interests of the Parent and Child in Requiring Due Process Safeguards.

It must be recalled that the District Court in the instant case did not exclude parents or guardians from participation in the institutionalization decision, but merely required procedural protections such as were already afforded under the state's Juvenile Code, as a check on parental (and professional) authority in this area.

Such a holding is fully consistent with the balancing approach adopted by this Court in the above-cited abortion cases. Concurring in *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, Mr. Justice Stewart and Mr. Justice Powell indicated that the issue might have been different if, instead of a situation where the parent exercised absolute control over the child's decision, the Court were considering a "provision requiring parental consent or consultation in most cases but providing for prompt (i) judicial resolution of any disagreement between the parent and the minor, or (ii) judicial determination that the minor is mature enough to give an informed consent without parental concurrence or that abortion in any event is in the minor's best interest."

Such a provision, said the concurring opinion, "would not impose parental approval as an absolute condition upon the minor's right but would assure in most instances consultation between the parent and child." *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 91 (Stewart and Powell, JJ., concurring); *cf. Bellotti* v. *Baird*, *supra*, 428 U.S. at 147.

This Court's opinions thus contemplate that in situations such as the case at bar, an acceptable formulation can be achieved which allows for parental involvement to an appropriate extent while preserving the rights of the minor child involved, and which utilizes a neutral body to resolve these different and potentially conflicting interests. The order of the court below does no more and, indeed, could do no less.

D. It Cannot Be Assumed That Parents, Faced With Legitimate Familial Problems, Will Always Act in the Best Interest of Their Children With Regard to Commitment to a Mental Institution.

As found by the court below, parents (or guardians), even with the best of motives, may not act, or be capable of acting, in the best interest of their children in seeking their institutionalization. 412 F.Supp. at 138; A. 765-766. This does not mean that such parents are acting malevolently or punitively, although a small number may do so.[25] What it does mean is that very often the child's

[25] Evidence that parents do not always act in the best interests of their children is best supplied by the examples of child abuse and neglect. The National Center on Child Abuse and Neglect estimates that if comprehensive reporting existed in all jurisdictions, there would be as many as a million reports of abused and neglected childern each year: approximately 200,000 abused and 800,000 neglected. It is estimated that 2,000 children die each year from child abuse and neglect related injuries. Child Abuse and Neglect Statistical Information Sheet, p. 4 (available from HEW's National Center for Child Abuse and Neglect).

problem is part of a larger familial problem, and that the entire family should be treated as a whole rather than isolating one member of the family in an institution. But familial problems may produce such a level of frustration and anxiety that parents are simply incapable of objectively considering the child's interests when they make the critical decision of institutionalization (A. 163-165, 482, 801, 804, 805; "Minors' Right to Due Process," *supra*, 52 Notre Dame Law. at 140-141).

In other words, children are likely to suffer or be blamed for problems that plague the entire family and for situations that require help for the family as a unit, not just for the child. See 412 F.Supp. at 133; A. 163, 371, 482-483, 749, 798-799. This being the case, the District Court rightly concluded, parents should not be in a position to make institutionalization decisions virtually on their own. 412 F.Supp at 138. Nor should they be in a position to waive a child's constitutional rights under such circumstances. 412 F.Supp. at 137, n. 54.

Other courts have also recognized that a child's best interest is not always the motivating factor behind the institutionalization decision. See, e.g., *Heryford* v. *Parker*, *supra*; *Saville* v. *Treadway*, *supra*, 404 F.Supp. at 432; *Horacek* v. *Exon*, *supra*, Order of June 4, 1974; *New York State Association for Retarded Children and Parisi* v. *Rockefeller*, *supra*, 357 F.Supp. at 762; *In re Long*, *supra*; *In re Sippy*, 97 A.2d 455 (D.C. Mun. App. 1953). As the Chief Justice put it several years ago,

> [l]awmakers in recent years have been sensitive to the need to make civil commitment difficult, recognizing the dangers of relatives "farming" out their kindred into mental institutions for motives not always worthy. *Kent* v. *United States*, 401 F.2d 408, 416 n. 4 (1968) (Burger, J., dissenting).[26]

[26] See also testimony of John Paton Filley, Director of Child and Adolescent Mental Health Services, Atlanta Division: "The problem here in part is the history and tradition of mental hospitals which have been dumping grounds in the past" (A. 767-768).

Children, especially those who cannot speak for themselves, must be protected from the risk of such inappropriate and harmful decisions.

E. Claims of Alleged Traumatizing or Disruptive Effects of Due Process Protections for Children Are Not Supported by the Record.

Defendants-appellants contend that a due process hearing prior to institutionalization will have a traumatizing effect on the child or divide and disrupt the family involved (defendants brief, p. 38).[27] However, in proceedings below, experts testified that a hearing may be beneficial for both parent and child (A. 179, 808). Properly administered, a hearing can impart to the child a sense that he is being dealt with fairly. A hearing may also help to relieve parents' anxiety or guilt by removing from them the necessity of making the final decision. Even assuming some unpleasantness or familial discord, it is hard to conceive of these effects as more traumatizing than the effects of indefinite commitment, especially if the institutionalization turns out to be inappropriate or unnecessary. Further, there may be cases where there is little or no family harmony left to preserve and where a hearing will hardly make matters worse. See the above quoted passage from *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 75.

Thus the reasons advanced for preserving a system in which the child's interests are not assured of representation cannot be supported on the basis of the record in this case, and, even on their face, do not justify the risk of inappropriate or unnecessary institutionalization.

[27] It should be remembered, again, that a formal hearing will not necessarily be held in every case as a result of the District Court's decision.

CONCLUSION

For the reasons set forth above, the American Bar Association urges this Court to affirm the judgment and decree of the District Court.

Respectfully submitted,

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APPENDIX

APPENDIX

ABA COMMISSION ON STANDARDS OF JUDICIAL ADMINISTRATION

*Standards Relating to Trial Courts.**

2.72 Proceedings Concerning Involuntary Care and Treatment.

In civil proceedings for commitment of the mentally ill, and in all other proceedings in which a disposition of a person may be made on account of his mental or physical condition, the court should ensure that the disposition is made on the basis of adequate information, in accordance with applicable law, and with due regard for the rights of the individual and of the public.

(a) *Procedural Requirements.*

(1) The person who is subject to the proceeding and his family or others immediately concerned for his welfare should be given adequate notice and an opportunity to be heard.

(2) The court should formulate clearly the issues to be resolved, with particular regard for the matters to be considered in the course of medical, psychological, or psychiatric examination and to be made the subject of expert testimony.

(3) Clinical evaluation should be made by professionally qualified persons on the basis of examination and other diagnostic procedures that conform to professionally recognized standards. The person who is the subject of the proceeding should be entitled to obtain and present such an evaluation on his own behalf, at public expense if he lacks the means to obtain it himself. Examiners

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* Draft approved at February, 1976, mid-year meeting.

should be required to testify as to the extent of their examination and the grounds for their conclusions. Except on stipulation of both parties, the testimony of all witnesses, including expert witnesses, should be presented in open court, subject to cross-examination, and included in the record of the proceeding.

(4) The person subject to the proceeding should be entitled to the assistance of counsel as provided in Section 2.20.

(5) In exercising its power to order care and treatment, the court should consider possible alternative dispositions, imposing only as much restraint as is necessary for protection of the individual, his family, or the public, or for accomplishment of required treatment.

(6) When commitment is ordered, the court should specify its purposes, the terms and conditions of any custody or restraint that may be directed, and a time limit, upon the expiration of which the matter is to be brought before the court for further consideration unless the person has been discharged prior to that time according to law.

(7) Whenever a person is found to be mentally ill or mentally retarded or is committed to an institution where he may be unable to take an active part in management of his property or business interests, and it appears that the commitment may be of long duration, the court should inquire into the nature of such interests and the possibility that guardianship of his property or like safeguards should be established to protect them.

(8) Observational commitments. Involuntary commitments for the purposes of observing the individual's mental or physical condition should be to the least restrictive environment in which the observation can be conducted and only for that period of time which is reasonably necessary to complete such observation.

(9) Emergency commitments. Emergency commitments without judicial proceedings should be permitted only in cases of extreme physical danger to human life, health, or safety, and should not be continued beyond the time reasonably necessary to arrange for a preliminary hearing before a judge.

(b) *Staff Assistance.* The court should have sufficient supporting staff and access to psychiatrists and other professionally qualified experts to carry out its responsibilities under this Section.

COMMENTARY

In recent years the traditional procedures for civil commitment of the mentally impaired, and procedures involving defendants in criminal cases who plead insanity or whose competence to stand trial is in question, have been augmented by an array of statutory procedures for commitment of narcotics addicts, alcoholics, and persons manifesting such types of statutorily defined social deviance as "sexual psychopathy" and "defective delinquency." Because these proceedings are generally termed civil rather than criminal, even when they arise out of criminal prosecution, fewer procedural protections are generally afforded the persons subject to them. The distinction between civil and criminal in many of these cases, however, is more apparent than real. Commitment to an institution on the ground of mental or physical condition is a deprivation of liberty and has many of the characteristics of penal sanctions: confinement (often under harsh conditions), isolation from family and friends, inability to earn a living, persisting social stigma, and sometimes loss of civil and professional rights. Like criminal prosecution, it is often the result of an alleged offense against the law or mores of the community. Procedural safeguards in these cases should not depend on mechanical application of a dichotomy between civil and criminal procedures.

The role of the court in commitment and related procedures should be clearly understood as including responsibility for determining the legal and factual issues that may be presented. The court should not simply ratify recommendations of medical examiners on the assumption that the question is one of medical diagnosis. Statutory definitions of the classes of persons subject to these proceedings do not necessarily correspond to any generally accepted medical diagnostic category. Moreover, psychiatric diagnosis by one diagnostician may differ greatly from that by another who is equally well qualified, and may sometimes be influenced by irrelevant or insubstantial therapeutic, social, or institutional considerations. The lack of precise criteria for determining the potential dangerousness of an individual should be taken into account, as should the tendency of medical witnesses to overpredict dangerous behavior. The medical expert must provide the court with the medical facts and medical opinions essential to a decision, including diagnosis, prognosis, suitability of proposed treatment, prospect of improvement under possible alternative dispositions, and the like. However, the ultimate decision is not essentially a medical one and involves a substantial element of legal discretion. The special problems encountered in these cases make it desirable that judges have been prepared by experience or training for their role. [Reference omitted.]

Notice and an opportunity to be heard should be provided even though the person subject to the proceeding appears to be mentally incapable of acting upon them. Notice may be delivered by a social worker or other trained person acting on behalf of the court who can explain its meaning and offer assistance in obtaining counsel and making preparations for the hearing. Notice of the hearing should also be given to relatives or friends who may assist the respondent or act in his behalf. Notice should be given sufficiently in advance of scheduled

court proceedings to afford a reasonable opportunity for preparation, and should inform the person with particularity of the basis for his detention, his right to counsel and to trial by jury (where available) and the standard upon which he may be detained.

The person who is subject to commitment should be personally present, except where the court finds that he is incapable of attending the hearing or that attending the hearing would worsen his condition or might incite him to injure someone else as a result of hearing the testimony. He should in any event be represented by counsel. See Section 2.20.

Where the respondent is in such a condition that he cannot be present at the hearing, a conference with the judge may allow him to state his case without being required to be present at the formal hearing, but such a conference should not take the place of an evidentiary hearing. Disposition should be made only upon a hearing at which medical and other witnesses are present and subject to cross-examination by counsel and questioning by the court unless the parties agree to presentation on the basis of written documents. Hearings should be on a formal record and decisions based on written findings of facts.

Hearings under sex-psychopath and similar quasi-criminal statutes should provide all the procedural safeguards of a criminal trial. In cases where determination of mental condition is related to criminal proceedings, a separate hearing should be held on mental condition, with adequate notice to the defendant of the questions at issue and the possible consequences of the determination.

The usefulness of medical reports and testimony can often be greatly improved if the court advises examiners and witnesses in advance of the kinds of information it requires for an informed decision. This can be done

through examination forms stating the legal questions before the court (for example, whether the individual is competent to stand trial), and indicating the facts required for a finding on the question at issue (for example, whether he could cooperate with counsel in his own defense). Examiners should be required to state the nature and extent of their examination and the grounds on which they base their findings and conclusions.

Counsel for the respondent should be afforded sufficient time and resources to consult with his client, secure independent professional examination if desired, and inform himself about possible alternatives to commitment. Special training for counsel in mental illness cases can be helpful in improving the quality of representation.

In reaching a disposition, courts should consider all reasonable alternatives such as voluntary hospitalization and treatment in the community without full-time hospitalization. Dispositions should provide for the minimum amount of restraint consistent with accomplishing the purposes of the law.

Commitments should be limited to a relatively short period, at the end of which the necessity of further commitment should be judicially determined. Periodic review of the status of committed persons should be initiated by the court unless a public guardian or defender agency can assume responsibility for doing so. The review should involve notice and formal hearing, with the respondent represented by counsel and medical witnesses subject to cross-examination as in the original commitment proceeding. All reasonable alternatives to commitment should again be considered, and a realistic assessment made of the likelihood of accomplishing further therapeutic objectives by commitment.

Supreme Court, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 75-1690

JAMES PARHAM, ET AL., *Appellants*

v.

J.L. & J.R., ET AL., *Appellees*

On Appeal From the United States District Court for the Middle District of Georgia

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Brief of American Psychiatric Association, American Society for Adolescent Psychiatry, American Academy of Child Psychiatry, and American Association of Psychiatric Services for Children, as Amici Curiae

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 75-1690

JAMES PARHAM, ET AL., *Appellants*

v.

J.L. & J.R., ET AL., *Appellees*

On Appeal From the United States District Court for the Middle District of Georgia

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Brief of American Psychiatric Association, American Society for Adolescent Psychiatry, American Academy of Child Psychiatry, and American Association of Psychiatric Services for Children, as Amici Curiae

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INTEREST OF AMICI CURIAE

The American Psychiatric Association, founded in 1844, is the nation's largest organization of qualified doctors of medicine who specialize in psychiatry. Almost 24,000 of the nation's approximately 30,000 psychiatrists are members of the Association. It has participated as an amicus curiae numerous times in cases throughout the country involving mental health issues.

The American Society for Adolescent Psychiatry is a nationwide organization of approximately 1,200 doctors of medicine who specialize in the practice of adolescent psychiatry. The American Academy of Child Psychiatry is a nationwide organization of approximately 1,600 doctors of medicine who specialize in the practice of child psychiatry. The American Association of Psychiatric Services for Children is a national multi-disciplinary organization of child mental health agencies and professionals, whose membership includes 175 separate agencies with total staffs of approximately 10,000 people.

Amici believe this case to be of great significance to the quality of care available to mentally ill children. As organizations whose members have devoted their lives to the delivery of mental health care in this country, Amici hope that the clinical insights which they have developed will assist this Court in resolving the important constitutional issues presented by this case.

CONSENT OF THE PARTIES

Amici are filing this Brief with the consent of both parties, whose jointly signed letter of consent has been filed with the Clerk.

STATEMENT OF THE CASE

This case is here on appeal from a decision by a three-judge United States District Court for the Middle District of Georgia invalidating Georgia Code Annotated § 88-503.1(a), which governs the admission of children under age 18 to state mental hospitals. The named plaintiffs are two children, aged 12 and 13 at

the time the case was filed, who were hospitalized at Milledgeville State Mental Hospital. These plaintiffs filed a class action against officials responsible for administering the Georgia Department of Mental Health, suing on behalf of "all persons younger than 18 years of age now or hereafter received by any defendant for observation and diagnosis and/or detained for care and treatment at any 'facility' within the State of Georgia pursuant to [§ 88-503.1(a)]." *J.L. & J.R.* v. *Parham,* 412 F. Supp. 112, 117 (1976). Section 88-503.1(a), in relevant part, authorizes the admission to a state mental hospital of any child "under 18 years of age for whom such application is made by his parent or guardian" if the child is "found to show evidence of mental illness and to be suitable for treatment."

Plaintiffs sued under 42 U.S.C. § 1983, alleging that § 88-503.1(a) denied them due process of law insofar as it authorized hospitalization without providing a child "a meaningful and complete opportunity to be heard," and "without asuring him initial and periodic consideration of placement in the least drastic environment [*i.e.,* treatment setting]." 412 F. Supp. at 118.

The district court ruled that § 88-503.1(a) failed to satisfy the requirements of due process because it permitted parents or guardians to hospitalize children without a hearing. Accordingly, the court enjoined further application of the invalidated statute. The district court further ordered defendants to institute hearings within 60 days for all children then being held under § 88-503.1(a), either pursuant to the Juvenile Court Act or the involuntary commitment procedures

of the mental health laws,[1] or to release these children from any form of state care or custody. Finally, the court ordered defendants to expend the monies necessary to provide adequate non-hospital, community-based treatment facilities for the 46 children that defendants had previously determined could best be treated in such facilities.

This Court stayed the district court's order on July 2, 1976, and noted probable jurisdiction of this appeal on May 31, 1977.

SUMMARY OF ARGUMENT

This case presents novel and difficult questions concerning the treatment of mentally ill children and the proper procedures for parents and guardians to follow when residential psychiatric care is medically recommended for their children. The issues are complex, and their resolution will have a profound impact on the competing rights and interests of both children and their parents.

This Court has emphasized repeatedly that parents have a basic constitutional right and responsibility to control the upbringing of their children. *See, e.g.,*

[1] The Georgia Juvenile Code, applicable only to children under age 17, authorizes hospitalization only after a hearing unless the child is likely to harm himself or others or property. Ga. Code Ann. §§ 24A-1601-1602. In these "emergency situations," the child can be detained briefly without a formal hearing. Ga. Code Ann. § 24A-1701.

The involuntary commitment provisions of the Georgia Code likewise authorize hospitalization only after a hearing, absent emergency circumstances. Ga. Code Ann. §§ 88-504 *et seq.* The criteria for such commitments are that a mentally ill person either be "likely to injure himself or others" or "incapable of caring for his physical health or safety." Ga. Code Ann. § 88-507.1.

Wisconsin v. *Yoder,* 406 U.S. 205, 232 (1972); *Pierce* v. *Society of Sisters,* 268 U.S. 510, 534-35 (1925). This right is not without limitations, *see Planned Parenthood* v. *Danforth,* 96 S.Ct. 2831, 2842-2844 (1976); *Prince* v. *Massachusetts,* 321 U.S. 158, 166 (1944), but, absent extraordinary circumstances, it should be controlling in view of the fundamental legal and societal interest in preserving the integrity and autonomy of the family unit. The court below not only failed to give any consideration to this principle of parental rights and duties, but it also ignored the fact that in certain categories of mental health admissions the legal imposition of adversary hearing procedures, in the context of the delicate emotional problems presented by these parent-child conflicts, will prove therapeutically counter-productive for the child.

The decision below applies the deceptively simple syllogistic reasoning that a child's interest in avoiding admission to residential psychiatric care is an interest protected by the Fourteenth Amendment's Due Process Clause, and therefore that all the traditional elements of procedural due process must apply to all these cases. Such an approach should have been the beginning, not the end, of the analysis, however.

Once it is determined that due process applies, the courts must still undertake the separate and highly subtle determinaion of what process is due. *Goss* v. *Lopez,* 419 U.S. 565, 577 (1975); *Morrissey* v. *Brewer,* 408 U.S. 471, 481 (1972). Due process is a flexible concept, and its elements must be defined in each situation with full regard for the competing interests and practical consequences of their application. *Matthews* v. *Eldridge,* 424 U.S. 319 (1976); *Wolff* v. *McDonnell,* 418 U.S. 539, 563, 567 (1974).

The court below did not undertake such an analysis; instead it tried to fit the diverse situations presented by plaintiffs' class into a rigid due process model to which they do not conform. The court ignored the fact that the class of plaintiffs varies dramatically with regard to the factors most relevant to an assessment of the effect of the proposed procedures on the rights of children and their parents. The court also ignored the very real harms that formal adversary hearing procedures can create in certain categories of cases.

Amici recognize that there are serious flaws in our nation's system of mental health care for children. In some instances these problems may be exacerbated, rather than alleviated, by the decision below, however. Amici believe that this Court can and should identify certain well-defined categories of cases in which carefully crafted hearing procedures may be appropriate and helpful. But in other situations, the potential harm of such procedures far outweighs their possible value, and thus both law and logic demand that they be excepted from any constitutionally imposed rule.

Specifically, Amici contend that balancing the important competing interests at issue should lead this Court to except from formal hearing requirements those cases in which (1) parents in an intact family wish to admit (2) a pre-adolescent child (3) to an accredited institution (4) for a short-term period (*e.g.*, less than 45 days). In all other instances, Amici conclude that the court below properly ruled that due process protections are appropriate.

Finally, Amici believe that the court below correctly concluded that when, as here, the State Department of Mental Health has determined that the proper

treatment of children is in a non-hospital, community-based treatment facility, the Constitution requires the State to develop such facilities. Under the fundamental principles articulated in *Jackson* v. *Indiana,* 406 U.S. 715, 738 (1972), "due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *See also O'Connor* v. *Donaldson,* 422 U.S. 563 (1975). In Georgia, children are institutionalized in order to receive proper mental health treatment. Accordingly, the Constitution requires that when the State determines that such treatment is best provided in a non-hospital setting, the State must assure that such a setting exists.

I. THE DISTRICT COURT FAILED TO RECOGNIZE THE ESSENTIAL RESPONSIBILITIES AND RIGHTS OF PARENTS FOR THE UPBRINGING OF THEIR CHILDREN, AND THE POSSIBLE HARMS INVOLVED IN REQUIRING DUE PROCESS ADVERSARY HEARINGS IN ALL CASES.

As professional organizations whose members are devoted to assuring the highest quality of mental health care, Amici share the concern of plaintiffs and the court below that children frequently are admitted to mental health institutions that are not appropriate for their needs, or are allowed to remain in institutions far longer than medically desirable. In seeking to cure this problem, however, the district court attempted to fit this case into a traditional due process mold to which it does not easily conform.

In particular, while Amici support much of the analysis and many of the conclusions implicit in the ruling below, we nevertheless believe that the court's ultimate holding—mandating a due process hearing for

all children under 18 years old—was insufficiently sensitive to the various needs of the different subgroups that constitute plaintiffs' class.

In assessing the constitutional validity of § 88-503.1 (a), the lower court properly found that the statute could not withstand scrutiny because it authorized the indefinite hospitalization of *all* children—regardless of age and irrespective of whether they are hospitalized by their parents or by a state agency acting as legal "guardian." On this basis, the court concluded that "[t]his statute supplies not the flexible due process that the situation of the plaintiff children demands but instead, absolutely no due process." 412 F. Supp. at 139.

While the court's constitutional conclusion is unobjectionable, its remedy belies the flexibility that it urged. Relying heavily on cases such as *In re Gault,* 387 U.S. 1 (1967), the court decided that because § 88-503.1(a) was invalid, children in Georgia could be hospitalized only pursuant to other statutes, specifically the Juvenile Court Act and the provisions of the mental health code governing involuntary commitment. These statutes, in effect, require a preadmission hearing or, in emergency situations, a hearing shortly after hospitalization. *See* note 1, *supra.*

In ordering this remedy without analyzing its effect on the various subgroups in plaintiffs' class, the district court ignored the oft-repeated admonishment of this Court that "[o]nce it is determined that due process applies, the question remains what process is due." *Goss* v. *Lopez, supra,* 419 U.S. at 577; *Morrissey* v. *Brewer, supra,* 408 U.S. at 481. Due process is, of course, a flexible concept which must vary according

to the particular circumstances and competing interests involved in a specific situation. *Smith* v. *Organization of Foster Families for Equality & Reform,* 97 S.Ct. 2094 (1977); *Morrissey* v. *Brewer, supra,* 408 U.S. at 481. "[T]he interpretation and application of the Due Process Clause are intensely practical matters," *Goss* v. *Lopez, supra,* 419 U.S. at 578, and "[t]he very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation." *Wolff* v. *McDonnell, supra,* 418 U.S. at 560; *Cafeteria & Rest. Workers Union* v. *McElroy,* 367 U.S. 886, 895 (1961). Accordingly, "not all situations calling for procedural safeguards call for the same kind of procedure." *Morrissey* v. *Brewer, supra,* 408 U.S. at 481; *see Matthews* v. *Eldridge, supra.*

In the instant case, Amici believe that the lower court failed to take into account two fundamental factors that must be considered in any analysis of what process is due when parents seek to admit their child to a mental health institution: (1) the parents' independent constitutional right and responsibility to control the upbringing of their child; and (2) the severe harms that can be caused in certain situations by application of a traditional due process hearing procedure—which was designed for conflicts between the state and an individual—to the very different and emotion-laden situations that arise when the essential conflict appears to be between parent and child. Proper recognition of these factors should lead this Court to conclude that, while due process hearing procedures are appropriate in certain categories of children's mental health admissions, the remedy imposed by the district court nevertheless fails to reflect an adequate

regard for the important and sometimes competing interests at stake in the different categories of cases encompassed within this litigation.

A. Parents Have a Basic Constitutional Right to Control the Upbringing of Their Children

This Court has repeatedly emphasized the long-recognized right of parents to control the upbringing of their children. More than fifty years ago, in *Meyer* v. *Nebraska,* 262 U.S. 390, 399 (1923), the Court included within those liberties protected by the Fourteenth Amendment the basic right to "bring up children." Shortly thereafter the Court relied on the *Meyer* decision in *Pierce* v. *Society of Sisters, supra,* to declare unconstitutional a state law that required parents of children between eight and sixteen years of age to send their children to public, rather than private, school. The Court held that it was "entirely plain that the [statute] unreasonably interferes with the liberty of parents and guardians to direct the upbringing and education of children under their control." *Id.* at 534-35. As these decisions recognize, parents' authority to control the upbringing of their children is "basic in the structure of our society." *Ginsberg* v. *New York*, 390 U.S. 629, 639 (1968).

More recently, in *Wisconsin* v. *Yoder, supra,* 406 U.S. at 232, the Court emphasized the "primary role of the parents in the upbringing of their children," noting that this relationship is embedded in "[t]he history and culture of Western civilization" and is "now established beyond debate as an enduring American tradition." *See also Stanley* v. *Illinois,* 405 U.S. 645, 651 (1972); *Prince* v. *Massachusetts, supra,* 321 U.S. at 166.

Finally, this past Term in *Smith* v. *Organization of Foster Families for Equality & Reform, supra,* the Court again stressed that the right of family privacy is predicated on "a relationship having its origins entirely apart from the power of the State . . . ," 97 S.Ct. at 2110, explaining:

> "The importance of the familial relationship, to the individuals involved and to the society, stems from the emotional attachments that derive from the intimacy of daily association, and from the role it plays in 'promot[ing] a way of life' through the instruction of children, *Wisconsin* v. *Yoder,* [*supra*], as well as from the fact of blood relationship." *Ibid.*

See also id. at 2119 (Stewart, J., dissenting); *Moore* v. *City of East Cleveland,* 97 S.Ct. 1932, 1935-36 (1977) (plurality opinion).

These parental rights are not, of course, without limitations. *See Prince* v. *Massachusetts, supra,* 321 U.S. at 166. Thus, while parents generally have the right to give or withhold consent for most surgical procedures for their children, *see Bonner* v. *Moran,* 126 F.2d 121 (D.C. Cir. 1941); *Scaria* v. *St. Paul Fire & Marine Ins. Co.,* 68 Wis. 2d 1, 227 N.W.2d 647 (1975), courts have overruled parents' religious objections and ordered blood transfusions that were necessary to save the child's life. *See, e.g., People* v. *Labrenz,* 411 Ill. 618, 104 N.E.2d 769 (1952); *Muhlenberg Hosp.* v. *Patterson,* 128 N.J. Super. 498, 320 A.2d 518 (1974). Such interference with parental discretion, however, has been rare and is generally limited to instances where a child is in danger of suffering grevious harm. *See, e.g., Planned Parenthood* v. *Danforth, supra,* where the Court held that a minor fe-

male's right to decide whether to terminate her pregnancy outweighs her parents' right to control her actions by refusing to consent to an abortion.[2]

With rare exceptions, such as those reviewed above, governmental respect for parental decision-making has been considered essential to preserving the integrity of family life. Under our social and legal system, parents necessarily must assume responsibility for the myriad of difficult decisions concerning the health and welfare of their children. A basic corollary of that responsibility or duty is the parents' right to make those decisions free from unreasonable outside interference. *See* Kleinfeld, *Balance of Power Among Infants, Their Parents and the State,* 4 Fam. L.Q. 409, 413 (1970). Day in and day out, parents are called upon to make decisions of vital significance to the child's "liberty" or "property" interests—should the child be sent to boarding school, have a tonsillectomy, be required to work after school? And, despite the importance of these decisions, it is seldom suggested that the child

[2] *See also Muhlenberg Hosp.* v. *Patterson, supra,* 320 A.2d at 521; Note, *State Intrusion into Family Affairs: Justifications and Limitations,* 26 Stan. L. Rev. 1383, 1398-99 (1974) (standard is one of "severity and irreversibility" of harm to child); Note, *Child Neglect: Due Process for the Parent,* 70 Col. L. Rev. 465, 472 (1970) ("the state should not be permitted to take this drastic step [intervening in parental decisions] without demonstrating that the child has been inflicted or threatened with serious harm"). *Compare In re Green,* 448 Pa. 338, 292 A.2d 387, 392 (1972) (state interest in child's health outweighs parents' religious belief only when child's life immediately imperiled), *with In re Seiferth,* 309 N.Y.2d 80, 127 N.E.2d 820, 137 N.Y.S.2d 35 (1955) (parental refusal to allow operation to correct cleft palate upheld), *and In re Hudson* 13 Wash. 2d 673, 126 P.2d 765 (1942) (parental refusal to permit removal of daughter's grossly deformed arm upheld, even though condition would result in permanent psychological and circulatory damage).

should have a right to legal representation and a hearing to review each such parental determination. The reason is clear: the parents' interest in preserving their authority and exercising their independent responsibility normally outweighs a child's interest in a legal procedure to question each such decision.

In sum, in determining what procedures should be required by the Due Process Clause when parents seek to admit their child to residential psychiatric care, the court below erred by failing to give any consideration to the parents' independent constitutional right and responsibility to control the care and upbringing of their children. This right is fundamental; in our society the fabric of family life is woven out of the diversity of our citizens and their differing family traditions. This rich heritage ought not readily be displaced by uniform solutions or procedures of government.

B. A Blanket Rule Requiring Immediate Due Process Hearings in All Cases Would Frequently Result in Psychological Harm to the Children.

Another factor which the lower court unfortunately failed to consider is the very real danger that traditional due process procedures may in certain cases inflict psychological harm on children because of the unique emotion-laden nature of the parent-child conflicts that will be aired in those hearings. It is dangerously easy for the courts to assume that the procedural model mandated for juvenile delinquency hearings, *see In re Gault, supra,* can be adapted with little modification to psychiatric admission cases. From a clinical standpoint, however, this is highly improper. Indeed, if the procedural rights granted to children

in order to oppose the state in a juvenile delinquency proceeding were applied without exception to cases where children oppose their parents' decision to obtain psychiatric help for them, the result might be to strain, if not irrevocably rupture, the essential emotional relationship between parent and child. *See generally Wolff* v. *McDonnell, supra,* 418 U.S. at 563, 567 ("there would be great unwisdom in encasing the . . . procedures in an inflexible constitutional straitjacket that would necessarily call for adversary proceedings [that would] very likely raise the level of confrontation"; rules of procedure should be "shaped by the consequences which will follow their adoption").

Amici must emphasize that judicial procedures that may be commonplace and comfortable for lawyers and judges are extremely unpleasant, if not traumatic, for children and parents caught up in what is at best a very difficult emotional process. The most conscientious parents frequently struggle for some time to accept the judgment of a psychiatrist that placement in a residential institution is in the best interest of their child. "For most parents hospitalization [of their child is] a traumatic experience. . . ." E. HARTMANN, ET AL., ADOLESCENTS IN A MENTAL HOSPITAL 84 (1968).[3] To

[3] "For most parents, the placement of a child in a psychiatric treatment facility entails considerable expense and some humiliation." Lessem, *On the Voluntary Admission of Minors,* 8 U. Mich. J. Law Reform 189, 203 (1974); *see* Mandelbaum, *Parent-Child Separation: Its Significance to Parents,* in G. WEBER & B. HABERLEIN, RESIDENTIAL TREATMENT OF EMOTIONALLY DISTURBED CHILDREN 68, 74 (1972):

> "What are the feelings of parents who face the prospect of residential treatment for their child? . . . [D]uring the admission procedure a universal reaction is that the child's need of residential treatment reveals their inadequacy as parents. They have been found deficient in qualities of goodness."

subject parents and children to the additional unpleasant ordeal of a hearing at which adversary counsel would cross-examine the parents concerning their motivations, good faith, and possibly their own emotional problems,[4] could have significant negative consequences.

First, it might deter some parents from proceeding with needed residential treatment for their children.[5] This is a serious problem because, in spite of the common and frequently justified criticisms of our nation's mental health institutions for children, the appropriate form of care and treatment for many disturbed children still includes some period of residential care.[6] In-

[4] *See* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 Cal. L. Rev. 840, 889-90 (1974):

> "In the hearing, the lawyer will in most cases want to examine the parents as witnesses in order to explore their reasons for seeking the child's commitment, their perceptions of the child's problems, and their relationship to the family's problems."

[5] A "normal" reaction to their child's emotional illness is for parents to look for reasons why they need not or cannot hospitalize their child. *See, e.g.,* Philips, *et al., Intake for Inpatient Care,* in S. SZUREK, I. BERLIN & M. BOATMAN, INPATIENT CARE FOR THE PSYCHOTIC CHILD 66, 68 (1971):

> "In our experience . . . many parents of severely disturbed childen ask for help in such negative and distorted ways as to half-invite rejection. Requests may be phrased: 'I am calling just to find out how long the waiting list is.'"

The additional hurdle of an adversarial hearing would further discourage, or be used as an excuse by, confused, dejected parents who, despite their better judgment, fear hospitalizing their child.

[6] *See, e.g.,* Khan, *"Mama's Boy" Syndrome,* 128 Am. J. Psychiatry 712 (1971). *See generally* Tizard, *et al., Environmental Effects on Language Development: A Study of Young Children in Long-Stay Residential Nurseries,* in S. CHESS & A. THOMAS, ANNUAL PROGRESS IN CHILD PSYCHIATRY AND DEVELOPMENT 705, 728 (1974):

> "In conclusion, we would argue that in view of the wide va-

deed, studies continue to suggest that one of the fundamental problems in mental health today is not "over-institutionalization," but rather the shortage, due to lack of resources, of high-quality residential facilities. *See* R. GLASSCOTE, M. FISMAN & M. SONIS, CHILDREN AND MENTAL HEALTH CENTERS, PROGRAMS, PROBLEMS, PROSPECTS 24 (1972) (number of young people requiring psychiatric treatment is "many times the number who at present are receiving any treatment"); JOINT COMM. ON MENTAL HEALTH OF CHILDREN, CRISIS IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's, at 6 (1969) ("for every child admitted to [a good private residential facility] ten or more are turned away because of lack of space"; "the fact is that only a fraction of our young people get the help they need at the time they need it"). Hospitalization must be considered as only one phase, but sometimes a necessary phase, of the total treatment of many patients. *See, e.g.,* Rabiner & Lurie, *The Case for Psychiatric Hospitalization,* 131 Am. J. Psychiatry 761, 764 (1974).

In short, Amici firmly believe that hospitalization is helpful to many patients, both adults and children, and is the treatment of choice for many acute and severe psychiatric conditions.[7] Judicially imposed procedural

riety of institutional settings, and the evidence from this and earlier studies . . . of their varying effects on development, it is perhaps time to abandon the concept of 'the institution' as a factor in development, and to replace it with a consideration of the effects of different institutional regimens on different aspects of development."

See also Rinsley & Inge, *Psychiatric Hospital Treatment of Adolescents,* 25 Bull. of the Menninger Clinic 249 (1961); D. HOLMES, THE ADOLESCENT IN PSYCHOTHERAPY 132-41 (1964).

[7] While reliable empirical data are lacking in this area, "[c]linical impressions do suggest . . . that good residential treatment programs lead to more satisfactory development and functioning in the child than might otherwise have occurred if the child had not been admitted." Lewis & Solnit, *Residential Treatment,* in A. FREEDMAN, ET AL., COMPREHENSIVE TEXTBOOK OF PSYCHIATRY II, at 2249 (1975).

requirements therefore should not be so onerous as to deter parents from seeking residential psychiatric care for their children in appropriate cases.

Second, hearing procedures can severely strain the relationship between the parent and the child. The aspect of hearings which is most distressing to children relates to the "negative remarks made about them by the parents," Snyder, *The Impact of the Juvenile Court Hearing on the Child,* 17 Crime and Delinquency 180, 189 (1971), thereby adding to the burden of a family attempting to deal constructively with its problems. For example, in possibly analogous cases dealing with "persons in need of supervision," or minors who traditionally have fallen under the jurisdiction of the juvenile court, studies show that judicial proceedings are "damaging to an already strained family situation":

> "Whatever motivates parents to bring their children before the court, the courtroom experience does not generally ameliorate existing animosities, despite the supposedly 'protective' nature of the proceeding. To the contrary, able defense attorneys become surrogate parents and necessarily proceed to 'destroy' the natural parents verbally on cross-examination before the defendant-child." Stiller & Elder, *PINS—A Concept in Need of Supervision,* 12 Am. Crim. L. Rev. 33, 59 (1974).

Because of these problems, formal adversary proceedings may create more family dissension and risk

the further breakdown of family structure, especially in cases involving younger children. *See* Note, *Recognition and Protection of the Family's Interests in Child Abuse Proceedings,* 13 J. Fam. Law 803, 813 (1974). Thus, rather than deterring parents from "dumping" their children, due process hearings in some instances may enhance the likelihood of just such an unwanted and negative outcome.

The traditional court sanction directed towards parents who mistreat their children through child abuse or child neglect is to remove the child from the home. In the situations of concern to the court below ("unneeded" child hospitalization), such a sanction would be meaningless. Confronted by a "victorious" child—one not permitted by a court to be hospitalized—parents may feel they have no other alternative but to turn the care of the child over to the state. As a result, a child who might have been hospitalized, visited by his or her parents, and eventually returned home, instead would be confronted with the complete rupture of the parent-child bond.

Finally, studies have found that in certain instances court hearings create a considerable feeling of uneasiness, if not anger, in the child.[8] Based upon clinical experience, Amici have found that younger children, in particular, are likely to be intimidated and confused by formal hearing procedures. The course of the child's therapy may be harmed by what the child might perceive as an attack on the competence and judgment of the child's therapist who is recommending residential treatment.[9]

[8] *See* Snyder, *The Impact of the Juvenile Court Hearing on the Child, supra,* at 181.

[9] *See* Miller, *Children's Rights and the Juvenile Court,* in AMERICAN PSYCHIATRIC ASS'N, SCIENTIFIC PROCEEDINGS IN SUMMARY FORM, 129TH ANNUAL MEETING 35-36 (1976):

> "The adversary role of lawyers is antithetical to good child care for a variety of reasons. The disturbed child who goes to court abandons the right to confidentiality and a perceived attack on a therapist may negate the value of therapy. A child may perceive a therapist as being devalued. Repeated legal recheck as to the necessity for treatment can create doubt in the child as to whether the designated helpful person can be trusted."

In short, as this Court recently recognized in a case presenting issues essentially identical to the instant case, "such a hearing with its propensity to pit parent against child might actually be antithetical to the best interest of the young juveniles." *Kremens* v. *Bartley,* 97 S.Ct. 1709, 1718 (1977).

Not only do hearings create substantial risks of harm in some cases, but their supposed benefits in these situations are often overstated. Unfortunately, the promise of procedural due process as an effective check on improper institutionalization frequently proves illusory. Most judicial commitment proceedings are "perfunctory, ritualistic, impersonal, superficial, and presumptive of mental illness." Beran & Dinitz, *An Empirical Study of the Psychiatric Probation-Commitment Procedure,* 43 Am. J. Orthopsychiatry 660 (1973).[10] Thus, simply providing hearing procedures, especially before there is sufficient opportunity for institutional psychiatrists to work with the child and

[10] These authors report one study of 64 such hearings which found that the average hearing lasted only 4.45 minutes, with the court most often accepting uncritically the psychiatric recommendation. *Id.* at 664, 667. Other studies have reached similar conclusions. *See, e.g.,* T. SCHIFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY 135 (1971).

present a full report and meaningful evaluation to the tribunal, may not provide the significant protection plaintiffs seek. Nor will it contribute to dealing with the larger problem of improving the care and treatment available for mentally ill children.[11]

Moreover, while advocates of hearing procedures point out that psychiatric commitment in our society unfortunately continues to carry with it an element of stigma,[12] they fail to recognize that such stigma is far more likely to result from a procedure by which a court hears evidence and makes a judicial commitment determination than in instances where a child is admitted to a hospital by his or her parents, without court intervention.

It should further be noted that even with truncated hearings the procedural system mandated by the court below would be extremely time-consuming and expensive. After performing other medical and administrative duties, the average hospital staff psychiatrist is able to devote only 47 percent of his or her time to direct patient care. *See* JOINT INFORMATION SERVICE, ELEVEN INDICES 14 (1971). Any significant increase in

[11] *See* Tamilia, *Neglect Proceedings and the Conflict Between Law and Social Work*, 9 Duquesne L. Rev. 579, 589 (1971) ("Equal justice through procedural safeguards that does not require substantive justice for each individual is not enough"); J. POLIER, THE RULE OF LAW AND THE ROLE OF PSYCHIATRY 100 (1968):

> "While the progress made in protecting the constitutional rights of the child in the adjudicatory process is to be welcomed, it will in no way compensate for the lack of dispositional remedies. *Gault* may protect some children from unfair hearings and wrongful findings, but it will not provide one dollar's worth of professional mental health services or one hour of care for any troubled child."

[12] *See generally* Roth, *Some Comments on Labeling*, 3 Bull. Am. Acad. Psychiatry & Law 123 (1975).

the number of hearings required not only would encroach still further on the psychiatrists' limited time for patient care, it also would require the expenditure of substantial amounts of money for legal fees, court personnel, etc.—costs which most likely would be drawn from already inadequate state mental health budgets.[13]

Amici recognize that abuses occur under the present system. Unfortunately, all too many of the nation's psychiatric institutions are unaccredited and lack the resources necessary to provide high-quality care and treatment for the many children requiring that assistance.[14] Nor can there be any doubt that in some cases unfit parents may seek to abandon their responsibilities by "dumping" their children into inappropriate residential institutions. But the remedy for these problems must be fashioned carefully by the courts so as not to deter the appropriate use of high-quality institutions by the vast majority of conscientious parents who are seeking help for their disturbed children. In the section that follows, Amici will suggest how the Court should balance these factors in order to provide for due process hearing procedures in the situations where they can be most effective, while avoiding the

[13] *See* Friendly, *"Some Kind of Hearing,"* 123 U. Pa. L. Rev. 1267, 1276 (1975):

> "It should be realized that procedural requirements entail the expenditure of limited resources, that at some point the benefit to individuals from an additional safeguard is substantially outweighed by the cost of providing such protection, and that the expense of protecting those likely to be found undeserving will probably come out of the pockets of the deserving."

[14] *See* JOINT COMM. ON MENTAL HEALTH OF CHILDREN, *supra* at 42 (1969) ("most [residential care facilities for mentally ill children] are disgraceful and intolerable").

adverse consequences that inevitably would follow from the undiscriminating approach of the court below.

II. BALANCING THE COMPETING CLAIMS AND INTERESTS AT STAKE IN THIS CASE, THIS COURT SHOULD EXCEPT FROM DUE PROCESS HEARING REQUIREMENTS THOSE CASES IN WHICH (1) PARENTS IN AN INTACT FAMILY WISH TO ADMIT (2) A PRE-ADOLESCENT CHILD TO (3) AN ACCREDITED INSTITUTION (4) FOR A SHORT-TERM PERIOD.

Despite the problems and shortcomings of providing due process hearings for children who are to be hospitalized for mental health treatment, Amici nevertheless believe that there are circumstances where some form of hearing is constitutionally appropriate. It is a well-recognized clinical fact that extended hospitalization in an inappropriate facility can have serious debilitating effects on a child's development. *See generally* B. FLINT, THE CHILD AND THE INSTITUTION (1966); S. PROVENCE & R. LIPTON, INFANTS IN INSTITUTIONS (1962). In view of this fact, Amici believe that in certain instances a due process hearing, informed by proper clinical judgments, can serve an important purpose; it may help eliminate needless hospitalization by eliciting information that may result in placing a child in a non-hospital treatment setting or allowing the child sensibly to remain with his or her family.

In large measure, due process hearings for children are needed because most states are unwilling to devote the resources necessary to provide proper mental health care for their citizens. In this regard, appellants have mistakenly attempted to characterize the decision below as resting on the fact that psychiatry is an "inexact science" and that "psychiatrists are capable

of erring." (Appellants' Brief at 15, quoting 412 F. Supp. at 138.) A fair reading of the opinion, however, makes clear that the court placed the blame precisely where it belongs—on the state. In the court's words:

> "This court is impressed by the conscientious, dedicated state employed psychiatrists who with the help of equally conscientious, dedicated state employed psychologists and social workers, faithfully care for the plaintiff children *to the extent that state furnished resources and facilities permit.*" 412 F. Supp. at 138 (emphasis supplied).

Moreover, the court did not suggest, as appellants argue, that psychiatric fallibility was a "*justification* for . . . dilut[ing] the authority of a parent to seek and obtain medical assistance for his child, . . ." (Appellants' Brief at 15 (emphasis supplied).) Rather, the court simply stated that such fallibility meant that psychiatrists

> "cannot statutorily be given the power to confine a child in a mental hospital without procedural safeguards being imposed to guard against errors in judgment and/or the arbitrariness that the best of us humans exhibit from time to time." 412 F. Supp. at 138.

While Amici disagree in part with the court below in that we believe that there are countervailing factors that justify foregoing hearings in certain circumstances, we do not maintain, as do appellants, that psychiatric expertise can justify the elimination of due process hearings in *all* circumstances involving children under 18 years of age.

In elaboration of their effort to suggest that the decision below was predicated on the court's dissatis-

faction with psychiatry, appellants also make the unsupported assertion that the decision rested "on the idea that psychiatrists and psychiatry are unreliable, because psychiatrists supposedly disagree routinely on the particular labels and diagnoses to be given mentally ill persons." (Appellants' Brief at 17.) While Amici agree with appellants that psychiatric diagnoses—*i.e.*, identification of specific mental illnesses—are medically reliable, we recognize that this fact is not dispositive of the issue of when a hearing is constitutionally required. Even if a child is properly diagnosed, it does not follow that hospitalization is necessary or desirable. Rather, Amici believe that in appropriate circumstances a due process hearing may provide a reasonable forum for deciding what care should be provided to a properly diagnosed child. What follows is an analysis of those factors that should be considered in deciding when a due process hearing is both desirable and constitutionally required for a particular child.

Amici have already demonstrated that due process hearing procedures have a very real potential for harm to the interests of both parent and child in certain circumstances. The most serious deficiency of the decision below is that it ignored these potential harms and greatly oversimplified complex clinical realities in order to fit this case into a traditional, unbending due process mold. The class of plaintiffs before this Court is far from uniform, however, and the procedural requirements best suited to their differing interests must also vary, depending on several key factors totally ignored by the court below.

The interests of the child and the parent, and the concomitant potential of hearing procedures to produce benefit or harm, will differ radically, depending on

such factors as (1) the identity of the party seeking the child's psychiatric admission—whether it is a parent, or a state institution such as the welfare department; (2) the age of the child; (3) the quality of the proposed institution; and (4) the duration of the proposed commitment—whether, for example, it is a week of "respite care," designed to assist parents of a severely disturbed child, or whether instead it is an indefinite institutionalization of a child who may be expected to remain hospitalized for many years. Although critical, these factors were not considered in the district court's undifferentiated ruling requiring the same hearing procedures for all cases.

Amici respectfully urge this Court to recognize these very real differences as they relate to the propriety of imposing a traditional due process model, and to balance these factors so as to except from adversary hearing requirements any instance in which *all* of the following four factors are met: (1) parents in an intact family wish to admit a (2) pre-adolescent child to (3) an accredited institution (4) for a short-term period (*e.g.*, less than 45 days). Amici will now set forth the considerations that should lead the Court to this resolution.

First, the clearest line that should be drawn is between parent-initiated admissions and those instances in which an institutional guardian, such as a state welfare department, seeks to institutionalize a child. *See Smith* v. *Organization of Foster Families for Equality & Reform, supra,* 97 S.Ct. at 2114 ("Whatever liberty interest may be argued to exist in the foster family is significantly weaker in the case of removals preceeding return to the natural parent, and the balance of due process interests must accordingly be different"). The dangers of adversary hearing procedures referred to

in Section IB above—such as the risk to the parent-child emotional relationship inherent in such hearings —are not so compelling when a state agency, rather than a parent, seeks the admission. Moreover, the interest in parental integrity and the assurance of parental responsibility to minimize risks of abuse are not present in such cases. Accordingly, where a psychiatric admission is sought by a state institution, rather than a parent in an intact family, Amici believe that hearing procedures may be appropriate.

A second factor ignored by the court below is the age of the child. In remanding the case of *Kremens* v. *Bartley, supra,* this Court recently took specific note of "the very possible differences in the interests of the older juveniles and the younger juveniles." 97 S.Ct. at 1718. *See also Smith* v. *Organization of Foster Families for Equality & Reform, supra,* 97 S.Ct. at 2108 n. 44 ("children usually lack the capacity to make [a] decision [about foster care]"); *Planned Parenthood* v. *Danforth, supra,* 96 S.Ct. at 2844 ("our holding . . . does not suggest that every minor, regardless of age or maturity, may give effective consent for termination of her pregnancy"). These distinctions, recognized by this Court but ignored by the court below, are clinically important.

Amici believe that the distinction between adolescents and younger children is critical in assessing the impact of hearing procedures on children, and that this distinction should be legally recognized. The professional literature establishes that when children reach a *developmental age* [15] of approximately 13 they begin

[15] The concept of developmental age is quite different from that of chronological age and, in instances where the two differ significantly, developmental age should control. *See generally* T. ACHENBACH, DEVELOPMENTAL PSYCHOPATHOLOGY (1974). Mentally ill children frequently exhibit signs of developmental failure as a symptom of their illness. In view of this fact, any fixed chronological age is sure to be somewhat arbitrary. *See* note 16 *infra.*

to be significantly more capable of rational and analytical evaluation of their own best interests, as well as articulate expression of their views.[16] Adolescents will be far less threatened by hearing procedures and will be much more capable than pre-adolescents of using these procedures effectively. Indeed, Georgia has implicitly recognized this distinction between adolescents and younger children by authorizing children 14 years or older to volunteer themselves for mental health observation and diagnosis. Ga. Code Ann. § 88-503.1 (b).

A third factor ignored by the court below is the quality of the institution being proposed for the child. Amici believe that this factor not only has profound significance from the standpoint of the child and the mental health professional, but also should be relevant

[16] The authorities vary somewhat concerning the precise developmental age at which these skills are present. The consensus is that the age range is from 12-14. *See, e.g.,* Schwartz, *Children's Concepts of Research Hospitalization,* 287 New Eng. J. Med. 589 (1972); Note, *State Intrusion into Family Affairs: Justifications and Limitations, supra,* 26 Stan. L. Rev. at 1395. *See generally* J. PIAGET, MORAL JUDGMENT OF THE CHILD 17, 40 (1932); A. GESELL, F. ILG, & L. AMES, YOUTH: THE YEARS FROM TEN TO SIXTEEN 175-182 (1956); Neubauer, *Normal Development in Childhood* in B. WOLMAN, MANUAL OF CHILD PSYCHOPATHOLOGY 11 (1972). Amici believe that states should be given considerable flexibility in selecting an appropriate age distinction within this general range. *See Smith* v. *Organization of Foster Families for Equality and Reform, supra,* 97 S.Ct. at 2115 ("In a matter of such imprecision and delicacy" states are accorded wide constitutional latitude in drawing an appropriate line).

to the legal determination of what procedural rules are appropriate in these instances. *See Smith* v. *Organization of Foster Families for Equality and Reform, supra* (different constitutional procedures required where children are removed from a foster family and returned to natural parents than when children are sent from foster family to an institution). The sad truth is that the present quality of mental health institutions for children varies dramatically throughout the nation. There are many excellent institutions that are fully staffed and possess the resources necessary to provide a child with prompt treatment that is best suited to his or her needs. Many other institutions, however, are woefully lacking in trained staff and resources and in some cases may do little more than "warehouse" children. The Joint Commission on Accreditation of Hospitals, a recognized professional body which certifies institutions as meeting the minimum standards necessary for appropriate care, has denied accreditation status to numerous institutions throughout the country which are failing to provide adequate mental health care for children and adolescents.

Amici believe that the risk of psychological injury to children who are placed in such unaccredited institutions is sufficiently great to outweigh the possible harm of hearings. Hence, Amici recommend that no admission to an unaccredited institution should be sanctioned by the state absent a due process hearing at which the alternatives to such a placement would be fully evaluated.

Finally, the district court lumped together in its ruling virtually all admissions, regardless of duration.

Amici believe that in view of the potentially harmful aspects of admission hearings discussed above, a constitutionally imposed procedural rule should not forbid states from taking into account the very significant differences between short-term and long-term institutionalization. It is well-recognized that families who seek to care for their mentally disturbed children at home have episodes of crisis that may be effectively relieved by brief periods of hospitalization for these children. Such temporary crisis intervention is often sufficient to resolve a pattern of intensifying and destructive conflict. Similarly, certain mental and emotional problems typically can be cured by short-term institutional care.

The court below was not totally unaware of this distinction between short- and long-term care. Indeed, what troubled the court was the power of parents under the Georgia statute "to *indefinitely* hospitalize their children in an arbitrary manner." 412 F. Supp. at 138 (emphasis supplied). Nevertheless, the court effectively mandated pre-admission hearings (or, in emergencies, hearings shortly after admission) irrespective of the nature or duration of the potential hospitalization. Such procedures needlessly impose a cruel price on the very people who are trying the hardest to care for their children by keeping them at home and relying only on brief periods of institutionalization. To force states to adopt such procedures as a constitutional requirement simply makes no sense.

This Court has already recognized and affirmed the appropriateness of a state's allowing *short-term* psychiatric institutionalization prior to commencement of due process hearing procedures. *Briggs* v. *Arafeh,* 411

U.S. 911 (1973), *aff'g summarily Logan* v. *Arafeh,* 346 F. Supp. 1265 (D. Conn. 1972). In *Arafeh,* the Court affirmed the decision of a three-judge United States District Court rejecting a constitutional challenge to a state statute that authorized involuntary mental hospital commitment of adults who are certified by physicians to be suffering from mental illness and to be dangerous to themselves or others. The statute in question authorized confinement without any prior notice or hearing, and provided that if the patient objected to the hospitalization and the state nevertheless wished to continue the commitment, the patient would receive the right to counsel and an adversary hearing "not more than 45 days" after the initiation of commitment proceedings. *Logan* v. *Arafeh, supra,* 346 F. Supp. at 1267 n.3. In language that is directly applicable to the instant case, the district court held that the 45-day period before hearing procedures would be required is not only constitutional, but entirely reasonable in light of the expert testimony from professionals in this field:

> "Testimony received from expert witnesses established that the [delay] after initial commitment before judicial proceedings must be begun is not simply for the purpose of delay. It has a positive aspect as well. There is a compensating advantage to the committed person because in many cases during this period the medical staff at the hospital can adequately alleviate his mental illness or by use of non-emergency diagnostic procedures determine that he is not a 'danger to himself or others.' In such cases, the stigma of court record is avoided and the length of confinement is shortened. It must be remembered that commitment has not been undertaken for the sake of penal detention. The patient is committed for

> treatment and care, and some knowledge of his mental condition can be gained by visual observation and diagnostic tests. This takes time. On the other hand, where a full blown court trial must be had pursuant to § 17-178, additional time to undertake more elaborate testing of the patient's mental condition, and a more detailed probe into his relevant history, by both the hospital authorities and the expert witnesses who will testify in behalf of the patient is needed.
>
> While it is possible that all of this could be concentrated into a shorter period of time, we are satisfied that the time which is allowed by the statute is not so unreasonably long as to amount to a denial of due process. The time provisions set by the legislature are fully supported by the opinions of competent physicians specializing in the treatment and care of persons suffering from mental illness. We hold that there is a rational basis for the time allowed by the statute." *Id.* at 1268-69.

The *Briggs* v. *Arafeh* precedent was followed recently in *Coll* v. *Hyland,* 411 F. Supp. 905, 910 (D.N.J. 1976) (three-judge court) (20-day delay between commitment and hearing held constitutional). *See also Saville* v. *Treadway,* 404 F. Supp. 430, 437-38 (M.D. Tenn. 1974) (upholding 45-day "respite care" and six-month "Short-Term Training Admissions" for mentally retarded children, absent hearing procedures); *Fhagen* v. *Miller,* 29 N.Y.2d 348, 278 N.E.2d 615, 328 N.Y.S.2d 393, *cert. denied,* 409 U.S. 845 (1972) (upholding procedure allowing confinement for 15-25 days prior to hearing). The court below in the instant case erred in ignoring this precedent, which is directly applicable here."[17]

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[17] Lower courts are required to give no less precedential weight

The four factors discussed above suggest the type of balancing approach that should be used in resolving this appeal. In cases where the state rather than the parents has initiated the commitment proceeding, there are insufficient countervailing factors to outweigh the child's right to a due process hearing. Similarly, if the proposed admission is to an unaccredited institution, Amici believe that the risk of harm to the child is high enough to outweigh the potential dangers inherent in hearing procedures—damage to family autonomy, psychological harm of parent-child conflict at a hearing, or the possibility that procedures will deter parents from initiating the admission. In addition, drawing a distinction based on the age of children is constitutionally appropriate because older children have an increased ability and interest in expressing their opinions.

The final distinction Amici urge—between short-term and long-term admissions—also flows logically from a consideration of the shifting interests and risks in these cases. A basic premise of admissions for a short period, such as 45 days, is that the parents intend to maintain or strengthen the family unit and will resume care of the child during, or at the end of, the 45-day period. Such a period allows for emergency psychiatric intervention, evaluation of the child's psychiatric needs, or short-term intensive treatment. In cases where continued institutionalization appears necessary, the short delay prior to a hearing would assist mental health professionals in developing the most appropriate information to present to a tribunal concerning the

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to this Court's summary affirmances than to its other holdings. *See Hicks* v. *Miranda*, 422 U.S. 332, 344-45 (1975).

child's condition and their recommended treatment plan. Because the basic premise of a rule allowing short-term institutionalization without prior hearing procedures is that the child will return home shortly, the danger of parental abuse, or "dumping," is lessened significantly. The deprivation to the child in terms of lost liberty is also reduced. Indeed, it is not substantially greater than the loss sustained by a child hospitalized for a serious but necessary surgical procedure. Given the desirability of minimizing parent-child conflict when it is expected that the child will be returning soon to the family, formal adversary proceedings in these cases should be avoided.

The situation is quite different, of course, when parents seek a long-term institutionalization of their child. Whether such a parental judgment is based on a genuine feeling that it is in the child's best interest, or on a bad faith effort to "dump" the child, it opens the prospect that the parents may terminate the primary intra-family relationship they have had with the child. Even if the parents will be frequent visitors or active participants in the course of institutional treatment, the child's primary frame of developmental reference most likely will shift to some degree from the family to the institution. Thus, the intact family unit is being replaced, through parental choice, by the mental hospital as the primary agent of child rearing during a significant period of child development. Because the parents have chosen to relinquish control of the child to the institution, the possibility of an adversarial conflict between parents and child would not pose as serious a threat to ongoing intra-family relationships in such instances as would be the case when only short-term institutionalization is sought.

For these reasons Amici believe that a proper resolution of the relevant factors would require that any due process hearing procedures mandated by the Court should *not* extend to those instances in which *all* of the following four factors are present: (1) parents in an intact family wish to admit (2) a pre-adolescent child to (3) an accredited institution (4) for a short-term period (*e.g.*, less than 45 days).[18]

III. THE DISTRICT COURT PROPERLY RULED THAT WHEN THE STATE DEPARTMENT OF MENTAL HEALTH DETERMINES THAT MEDICALLY APPROPRIATE TREATMENT FOR CHILDREN REQUIRES PLACEMENT IN NON-HOSPITAL, COMMUNITY-BASED FACILITIES, THE STATE MUST PROVIDE SUCH FACILITIES.

It is apparent that the district court was troubled by the lack of non-hospital treatment facilities in Georgia, and by the resultant antitherapeutic effects of needless prolonged hospitalization on mentally ill children. Each of the named plaintiffs, for example,

[18] Once it is determined in which instances due process hearings should be required, Amici urge the Court not to limit the states' flexibility in seeking to establish the most appropriate types of forums and procedures to implement that decision. In most instances, the judgment to be made concerning possible institutionalization of a child requires consideration of many factors in addition to the child's mental condition—for example, what is the situation in the home, and how can beneficial treatment and counseling for other members of the family be provided? Amici believe that courts may not be the ideal forum for such determinations. Rather, an administrative tribunal may be the most effective way to include all of the relevant input, psychiatric as well as legal, in the decision-making process. *See In re Roger S.*, Crim. No. 19558 (Cal. Sup. Ct. 7/18/77). *See also* Hoffman & Dunn, *Beyond* Rouse *and* Wyatt, *An Adminstrative-Law Model for Expanding and Implementing the Mental Patient's Right to Treatment*, 61 Va. L. Rev. 297 (1975). In short, states should be free to experiment with a variety of mechanisms for implementing due process hearing requirements.

had been hospitalized for more than five years. Moreover, as the court stated:

> "That state officialdom—knowing definitely since said November 1973 study commission report of the crying need for non-hospital, alternative resources for the care and treatment of plaintiff children, and further knowing from said report of the large number of children who would not need hospitalization if other forms of care were available—has failed to even endeavor to provide such alternative resources demonstrates that even well-meaning state officials cannot be given the unlimited statutory authority to determine under what circumstances and for how long plaintiff children will be confined and detained by the state in its mental hospitals." 412 F. Supp. at 138.

In response to this concern, the court below took a small, but significant, step toward improving the opportunity for mentally ill children in Georgia to receive medically appropriate treatment.

During discovery, defendants were asked "to designate the [living] situation in which they would like to see the [members of plaintiffs' class] placed in order to get optimal benefits." 412 F. Supp. at 124. In response, defendants stated that 46 of the approximately 200 members of plaintiffs' class who were then hospitalized "could be optimally cared for in another, less restrictive, non-hospital setting if it were available."[19] *Id.* at 125. In view of this admission, the district court, relying on this Court's decision in *In re Gault, supra,* 387 U.S. at 27, and *Jackson* v. *Indiana, supra,* 406 U.S. at 738, ordered defendants to

[19] Defendants specifically designated the appropriate treatment settings for each of these 46 children. *See* 412 F. Supp. at 124 n. 18.

"proceed as expeditiously as is reasonably possible (1) to provide necessary physical resources and personnel for whatever non-hospital facilities are deemed *by them* to be most appropriate for these children, and (2) to place these children in such non-hospital facilities as soon as reasonably appropriate." 412 F. Supp. at 139 (emphasis supplied).

This relief provides a basis for the beginnings of a sensible solution that is both medically and socially compelling.

There can be little doubt that long-term hospitalization for children has been seriously overutilized, often serving as a means of social control—rather than medical treatment—for unwanted children. *See* JOINT COMM. ON MENTAL HEALTH OF CHILDREN, *supra;* A STONE, MENTAL HEALTH LAW: A SYSTEM IN TRANSITION, ch. 9 (1975). This practice has had a devastating impact on the children who have been forced to suffer the debilitating consequences of prolonged, needless hospitalization. *See, e.g.,* JOINT COMM. ON MENTAL HEALTH OF CHILDREN, *supra*; B. FLINT, THE CHILD AND THE INSTITUTION, *supra.* It is a sad commentary on the way in which our society cares for its disabled youth.

Nor can there be any dispute that care of mentally ill children in community-based facilities is to be preferred when such treatment is medically appropriate. *See, e.g.,* R. GLASSCOTE, ET AL., *supra,* at 20; Reiger *Changing Concepts in Treating Children in State Mental Hospitals,* 1 Int. J. Child Psychotherapy 59 (1972).[20] The goal of treatment is to enable a child to

[20] *See also,* JOINT COMM. ON MENTAL HEALTH OF CHILDREN, *supra* at 39:

"Children are best cared for and treated in atmospheres more related to health and normal living than to illness. Every effort should be made to keep the child as closely as possible within his normal setting. This means that we must expand non-hospital treatment arrangements, particularly those that could be operated under the auspices of community-based facilities, such as community mental health centers, educational settings, and social service agencies."

live independently or with his or her family in the community; if he or she need not be isolated from the community to receive proper treatment, the likelihood that a child will be able to make an effective transition to independent or family living is obviously enhanced.

In considering the constitutional underpinnings for the ruling below, it should initially be pointed out that the decision is very limited in scope. The court ruled simply that when *the professionals who staff the State Department of Mental Health determine that it is medically preferable to treat the children for whom they have assumed medical responsibility in non-hospital settings, the state must provide such facilities.* As the court stated, "[i]t is not for this court of three lay judges to choose the appropriate, less drastic form of care for each of these children: that decision we leave to the professional judgment of the defendant psychiatrists." 412 F. Supp. at 139. Hence, this is not a case like *Lake* v. *Cameron,* 364 F.2d 657 (D.C. Cir. 1966), where a federal judge was ordered to conduct an inquiry into alternatives to hospitalization, prompting then-Judge Burger to dissent on the ground that "a United States court in our legal system is not set up to initiate inquiries and direct studies of social welfare facilities or other social problems." *Id.* at 663. Significantly, in this case, the federal court left the task of determining the appropriate treatment facility to the professionals in the Georgia Department of Mental

Health who are properly charged with making such a decision.

In view of the limited nature of this holding, it is clear that basic, established principles of constitutional law will more than suffice to sustain the decision. In *Jackson* v. *Indiana, supra,* 406 U.S. at 738, while dealing with mental health commitments, this Court held that:

> "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."

See also O'Connor v. *Donaldson, supra,* 422 U.S. at 574-75.

There can be no question that the children in plaintiffs' class are "committed" patients in the legal sense in which the *Jackson* decision used that term. It is clear that these children have not themselves voluntarily sought treatment.[21] Moreover, pursuant to state law, Georgia has agreed to take responsibility for the proper care of the children, and has authorized their admission to a state mental health facility. Indeed, it is precisely for these reasons that due process procedures apply to all these children. Hence, the threshold requirement of *Jackson* is satisfied.

The next inquiry under the *Jackson* standard requires ascertainment of the "purpose" to be served by the commitment of children under Georgia law. The

[21] This conclusion is supported by the fact that under Georgia law children aged 14 or over can voluntarily apply for mental health observation and diagnosis. Ga. Code Ann. § 88-503.1(b). These "voluntary" children, of course, are not part of plaintiffs' class.

standard for the commitment of children in Georgia is "evidence of mental illness" and "suitab[ility] for treatment." Ga. Code Ann. § 88-503.1(a). The state has further clarified its purpose by stating that "each person receiving services for mental disorders shall receive care and treatment that is suited to his needs . . ." Ga. Code Ann. § 88-502.3(a). Thus, the sole purpose of committing children in Georgia is to provide medically appropriate treatment."[22]

In view of this purpose, when the professionals who under state law are responsible for the care of children determine that the medically appropriate treatment setting is a community-based, non-hospital facility, the "nature and duration" requirement of *Jackson* requires placement in such a facility. Hospitalization (*i.e.*, the "nature" of commitment) is plainly inconsistent with the treatment purpose when hospitalization is not the preferred setting. Likewise, hospitalization in such circumstances undermines the "duration" requirement since it may well needlessly prolong the time for treatment because the appropriate facility is not being used.

To be sure, one possible result of affirming this portion of the ruling below might be to prompt Georgia to decide to refuse to provide any care for children from intact families who cannot best be treated in a hospital setting.[23] Amici would certainly assume, how-

[22] Children in Georgia are *not* institutionalized on the basis of being dangerous to themselves or others.

[23] While this may be an unfortunate result, Amici nontheless consider such a result preferable to hospitalizing children who are not suited to such treatment. The harsh reality is that it is better to leave a mentally ill child in an intact family than to warehouse

ever, that Georgia would choose to establish proper facilities for treating its needy children, rather than abandon them. Moreover, insofar as plaintiffs' class includes children who are wards of the state, rather than members of intact families, the principles of *Jackson* plainly require the development of proper treatment facilities for these children. Pursuant to its *parens patriae* responsibility, the state must insure that the "nature" of its wards' placements "bear some reasonable relation to the purpose" of those placements. Thus, when Georgia determines that proper care of its wards is in a community facility, it must provide such. To do otherwise would not only be constitutionally deficient, but would constitute "neglect" on the part of the state.

In any event, once it is determined, as it has been in this case, that the appropriate treatment facility for a child is a non-hospital setting, the Due Process Clause requires that the child no longer be hospitalized. Accordingly, the court below correctly ruled that as to the 46 children in question for whom the Georgia Department of Mental Health has already assumed responsibility, and who under state law are entitled to "treatment that is suited to [their] needs," the state must provide the proper treatment setting.[24]

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him or her in a hospital that is not medically suited to provide adequate treatment.

[24] Nor is it of any constitutional moment that development of proper facilities may require the state to expend funds. *See Estelle* v. *Gamble*, 97 S.Ct. 285, 290 (1976) ("elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration"). In fact, as the district court noted in this case, "[t]he creation and operation of appropriate non-hospital facilities for these children will save rather than cost money, *i.e.*, hospital care costs some $40,000 per year per child whereas group home care costs some $7,500 per year per child; residential treatment care centers cost $12,000 per year per child." 412 F. Supp. at 144.

CONCLUSION

For the foregoing reasons, Amici urge this Court to affirm the decision below except insofar as it mandates due process hearings when (1) parents in an intact family wish to admit (2) a preadolescent child to (3) an accredited institution (4) for a short-term period.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 75-1690

T. M. "JIM" PARHAM, ET AL., *Appellants,*

v.

J. L. AND J. R., ET AL., *Appellees.*

Appeal from the Judgment of the United States District Court for the Middle District of Georgia

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BRIEF OF *AMICI CURIAE*

American Orthopsychiatric Association, Children's Defense Fund of the Washington Research Project, Inc., Federation of Parents Organizations for the New York State Mental Institutions, Mental Health Association, National Association of Social Workers, National Center for Law and the Handicapped, and National Juvenile Law Center

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INTEREST OF AMICI CURIAE

Amici Curiae are seven organizations of mental health professionals, parents of children with emo-

tional handicaps and child advocates concerned with the legal rights and effective delivery of services to these children.[1]

[1] (1) The American Orthopsychiatric Association, an interdisciplinary organization of 4,000 members including psychiatrists, psychologists, social workers, educators and allied professionals concerned with the problems, causes and treatment of abnormal behavior;

(2) The Children's Defense Fund of the Washington Research Project, Inc. (CDF), a national, nonprofit, public interest organization which gathers evidence about, and attempts to address systematically, the conditions and needs of children in this country. CDF seeks to correct the problems uncovered in its research through the monitoring of federal and state administrative policies and practices, litigation, the dissemination of public information and the provision of support to parents and local community groups representing children's interests. One of CDF's primary concerns is children who have been unnecessarily institutionalized or placed in inadequate facilities. CDF attorneys are serving as counsel for plaintiffs in *Poe* v. *Califano*, No. 74-1800 (D.D.C.) (three-judge court), a case currently pending on cross-motions for summary judgment, which involves the same procedural due process question presented in this case.

(3) The Federation of Parents Organizations for the New York State Mental Institutions, an organization of 30,000 parents, relatives and citizens concerned with the treatment of patients in New York Department of Mental Hygiene facilities;

(4) The Mental Health Association, a citizens organization of one million lay and professional members whose primary purpose is to encourage efforts to provide better services for the mentally ill;

(5) The National Association of Social Workers, an organization of 70,000 professional social work members with chapters in 50 states devoted to the advancement of sound public policy for social work consumers as well as professionals;

(6) The National Center for Law and the Handicapped, established with HEW funding to provide legal assistance to promote the full social and legal integration of all disabled Americans;

(7) The National Juvenile Law Center, a national legal services support center, funded by contract with the Legal Services Corporation through a grant to St. Louis University School of Law. The Center provides assistance to legal services programs, public defenders and private attorneys representing indigent clients in the area of juvenile and family law. From time to time, the attorneys employed by the Center also act as *amicus curiae* in cases involving issues of substantial public interest and importance, including participation as *amicus curiae* in *J.L. and J.R.* v. *Parham* in the district court.

Amici have a strong personal and professional commitment to the delivery of high quality mental health services to children and adolescents. They believe that wherever possible such services should be administered in the community and on a voluntary basis. Children and adolescents are best treated and cared for by their own families in their normal surroundings rather than by removal from their homes and segregation in institutions for the mentally ill. Moreover, *amici* believe that in the great majority of cases non-institutional treatment or training can be successful when families are given the community support and specialized help they need for their mentally ill children. Accordingly, the *amicus* groups have worked for the creation of better and more diversified community-based facilities and programs for the mentally ill. They have increasingly emphasized the need for such programs and facilities for these children because they believe that appropriate and non-stigmatizing help in the early years provides the greatest opportunity for producing healthy and well-functioning citizens.

Amici do not oppose institutionalization of children and adolescents in all cases. They recognize that some children have such severe illnesses or need such specialized services that residential care outside the family may be necessary. But they are concerned that children should not be removed from normal family, peer and community contacts without a formalized and

searching inquiry into their needs. Although the majority of parents are normally conscientious advocates for their children, they are often beset by conflicts and confusion of their own and by apathy on the part of official agencies. Parents are often unaware of alternatives to institutionalization, when in fact their children might be treated in the community. Although *amici* are sensitive to the sometimes competing demands of due process and treatment, they believe that an erroneous decision to treat a child through confinement in a closed mental hospital may seriously jeopardize the health, safety and development of the child. Moreover, *amici* submit that a reasonable accommodation of treatment and due process demands can be achieved and further, that the requirement of evidentiary hearings in connection with proposed institutionalization of children and adolescents will confer important therapeutic and social benefits on the child and the family.

Amici represent mental health professionals—psychiatrists, psychologists and social workers—and parents, who deal on a day-to-day basis with the problems of emotionally disturbed children and adolescents. This brief will inform the Court of studies and experience relevant to the question of how and when due process procedures should be applied to the commitment of children in institutions for the mentally ill.

As the Court has been informed in a letter to the Clerk dated August 25, 1977, from counsel for appellants and appellees, *amici* have received consent from both parties to file this brief.

STATEMENT OF THE CASE

This class action was brought pursuant to 42 U.S.C. § 1983, 28 U.S.C. 1343(3) in the United States District

Court for the Middle District of Georgia challenging Georgia statute, 1833 Georgia Code Ann. § 88-503.1, which authorizes the indefinite confinement of children to state mental institutions with consent of their parents or guardians and without an evidentiary hearing. Under this section, applications for "voluntary" observation and diagnosis at a state mental health facility may be made on behalf of any child under 18 years of age by his parent or guardian. In the case of a dependent or neglected child, the guardian is frequently the State welfare department. If, following a staff interview, the superintendent of the institution finds the child "to show evidence of mental illness and to be suitable for treatment," the child may be detained at the facility "for such period and under such conditions as may be authorized by law."

The minor plaintiffs alleged that they were denied due process of the law under the Fourteenth Amendment to the U.S. Constitution because they were involuntarily confined in state mental hospitals without being afforded a meaningful and complete opportunity to be heard.[2]

After considering more than 20 depositions from lay and expert witnesses and relevant hospital records and statistical evidence, a three-judge district

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[2] Plaintiffs contended further that commitment to state mental facilities without initial and periodic consideration of placement "in the least drastic environment" violated their rights to substantive due process under the Fourteenth Amendment to the U.S. Consitution. The court ordered that the approximately 46 members of plaintiff class who were identified as amenable to treatment in a less drastic environment be provided with such facilities "as soon as reasonably appropriate." For the reasons set forth more fully at n. 3 *infra*, *amici* believe that this Court should not reach this issue in the context of this case.

court composed of Circuit Judge Bell and District Judges Owens and Bootle ruled, unanimously, that the "voluntary" admission and commitment procedures of § 88-503.1 were unconstitutional. (J.S. 1a) (412 F. Supp. 112).

Following the decision of the court below, the defendants appealed the judgment to this Court and made application for a stay pending appeal. A stay was denied by the district court, 412 F. Supp. 141 (1976), but granted by this Court, 96 S. Ct. 1503 (1976). Probable jurisdiction was noted on May 31, 1977, 45 U.S. L.W. 3733.

SUMMARY OF ARGUMENT

This case requires the Court to decide first, whether a state may itself, acting as guardian, directly confine children in state mental institutions without evidentiary hearings and, second, whether the state may by statute authorize parents or non-public guardians to confine children in such facilities without the protection of a hearing.

This Court has often been called upon to mediate between the interests of the family in conducting its affairs free from arbitrary state interference and the interests of the state in protecting the welfare of its young citizens.

In doing so, it has recognized a presumption in favor of parental prerogatives, stating that "the custody, care and nurture of the child reside first in the parents." *Prince* v. *Massachusetts,* 321 U.S. 158, 166 (1944). But it has also stressed that the state may intervene with regard to parental decisions where those "decisions will jeopardize the health or safety of the

child, or have a potential for significant social burdens." *Wisconsin* v. *Yoder,* 406 U.S. 205, 234 (1972). In addition, this Court has granted to children of all ages significant procedural due process rights when the state attempts to remove them from their homes and place them in juvenile institutions as a result of alleged delinquent conduct. *In re Gault,* 387 U.S. 1 (1967). This case, however, involves neither a state's efforts to curtail family authority nor its efforts directly to remove children from their homes; rather it involves an attempt by the state either directly to initiate institutionalization of children who are its wards without a hearing of any kind or, indirectly, to participate with or authorize parents or other guardians to institutionalize their children in state mental facilities, also without a hearing of any kind.

This Court has previously recognized that involuntary commitment to a mental facility involves a "massive curtailment of liberty," *Humphrey* v. *Cady,* 405 U.S. 504, 509 (1972). Certainly for adults, such a deprivation must be attended by due process procedural safeguards. *See O'Connor* v. *Donaldson,* 422 U.S. 563, 580 (1975) (Burger, C.J., concurring); *In re Ballay,* 482 F. 2d 648 (D.C. Cir. 1973). And there can be little doubt that due process safeguards would also apply to any attempt by the state to initiate the involuntary institutionalization of a child. Similiarly, the right to procedural due process also applies where the commitment is not labeled "involuntary" but the state is nonetheless an active participant in the institutionalization of children, either through its initiation of admission as their guardian or, where the commitment is initiated by parents, through its acceptance of the children and its operation of the facility in which they are placed.

Therefore the critical question before this Court is not whether due process applies to the commitment of children to mental institutions but, rather, what process is due. *Mathews* v. *Eldridge,* 424 U.S. 319 (1976).

An analysis of the potential harm to children from an erroneous commitment decision, of the risk of an erroneous decision under the Georgia "voluntary" commitment statute, and of the countervailing interests asserted in support of the Georgia statute shows that the present Georgia procedure is constitutionally inadequate. An unnecessary commitment to a mental institution imposes very substantial harm on a child both because the process of institutionalization is inherently detrimental and because harmful conditions exist in many mental institutions in this country. As a result of institutionalization, children's natural family and community ties are often severed. Moreover, the impact of institutionalization upon the intellectual and emotional development of children can result in irreversible damage to their future potential as adults. And, even if they are eventually released, the mere fact that children have once been institutionalized carries with it a lifelong stigma which may later cause them to be denied employment, licensing, education and access to health benefits.

The risk of error in mental health professionals' decisions to admit children is very high. Such decisions are frequently made hurriedly and with very little information. Institutional personnel have a strong predisposition to recommend commitment in doubtful cases, and psychiatric diagnoses are recognized to be highly unreliable. Because the high risk of erroneous commitment decisions is coupled with the grave harm

of commitment, an evidentiary hearing is constitutionally required.

The countervailing interests in the present Georgia statute which might be asserted by the State do not outweigh the child's need for an evidentiary hearing. Such a hearing is not inconsistent with the legitimate interests of parents or with the preservation of family autonomy. Parental decisions to commit their children are often the product of great stress, of acquiescence in recommendations by institutional personnel or lack of knowledge about available treatment alternatives. Frequently, parents' own interests or the interests of other family members are in conflict with what is best for the child. Accordingly, it cannot be assumed that parents will automatically make this decision based solely on what they perceive to be the child's best interests or that they are sufficiently impartial to judge those interests. Further, by providing an opportunity to explore alternatives to institutionalization, an evidentiary hearing would help to preserve the family's integrity.

When the state acts *in loco parentis* to initiate the institutionalization of a mentally handicapped child, concerns of family autonomy are not relevant and prolonged institutionalization is more likely. Nor does the state have a fiscal or administrative interest which outweighs the child's need for the evidentiary hearing.

Thus, analysis of the criteria set forth in *Mathews* leads to the conclusion that children who are to be committed to mental institutions have a due process right to an evidentiary hearing. Without expressing an opinion on such related issues as the proper forum for such a hearing or the applicability of formal rules of evi-

dence, *amici* submit that any hearing procedure adopted must contain, at least, the minimum safeguards that have traditionally been required in cases involving deprivation of liberty: notice, counsel and the opportunity for the child subject to commitment to confront and cross-examine witnesses.

In sum, providing an evidentiary hearing to children subject to confinement in mental institutions can help to decrease unnecessary and damaging institutionalization and to bring to bear on the unfortunate situation of emotionally disturbed children the attention and community resources they require.

ARGUMENT

I. THE DUE PROCESS CLAUSE APPLIES TO THE COMMITMENT OF A CHILD TO A STATE MENTAL INSTITUTION REGARDLESS OF THE CONSENT OF THE PARENT OR GUARDIAN.

This case raises the question of a child's constitutional right to due process of the law when his liberty is at stake because of a decision by his parent or guardian (including the state acting as guardian) to commit him to a state mental institution.[3] This Court has

[3] This brief will restrict itself to the procedural due process issue pending before this Court, *i.e.*, those procedures required by the Constitution in connection with a child's commitment to a mental institution. *Amici* recognize that a substantive due process issue has also been raised in the Questions Presented: whether a child who has been properly found to be in need of treatment for a mental illness must be placed for treatment in the least restrictive alternative. *Amici* support the position of appellees on this issue. But we believe that a decision on the issue in the context of the instant case, where it has been intertwined with the procedural due process issue, would be premature. Should the judgment of the court below on the procedural question be affirmed, the substantive due process issue would lack the requisite ripeness for a decision by this Court. Since an affirmance on the procedural issue would mean that the children committed under the invalid procedure were unconstitutionally committed, the appellant Department's first order of business would be to hold constitutionally appropriate hearings to determine if the children are in fact in need of treatment according to Georgia law. The substantive due process issue as to the nature of the treatment to which a child is constitutionally entitled does not arise until it is first properly determined that he is in need of treatment. *Cf. Richardson* v. *Wright*, 405 U.S. 208 (1972). If, on the other hand, the Court were to uphold the Georgia commitment procedure, thereby ratifying the State's decision to commit the children, we would suggest that the Court reserve judgment on the substantive due process issue and remand the case for the development of a more complete record on the issue because the record developed below focuses almost entirely on the procedural question. Because the substantive due process claim does not challenge the constitutionality of a Georgia statute or regulation on its face, it appears that in the event of a remand, this issue could be heard by a single district judge. *See Morales* v. *Turman*, 430 U.S. 322 (1977).

previously recognized that involuntary commitment to a mental facility involves a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972). Certainly for adults, such a deprivation must be attended by due process procedural safeguards. *See O'Connor* v. *Donaldson*, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring).[4] "Commitment must be justified on the basis of a legitimate state interest, and reasons for committing a particular individual must be established in an appropriate proceeding." *Id.* at 580. And there can be little doubt that due process

[4] *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973). *See also Lynch* v. *Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard* v. *Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *remanded on other grounds*, 414 U.S. 473, *redecided*, 379 F. Supp. 1376 (1974), *remanded on other grounds*, 421 U.S. 957 (1975), *redecided*, 413 F. Supp. 1318 (1976); *Dixon* v. *Attorney General*, 325 F. Supp. 966 (M.D. Pa. 1971); *Bell* v. *Wayne County*, 384 F. Supp. 1085 (E.D. Mich. 1974); *Doremus* v. *Farrell*, 407 F. Supp. 509 (D. Neb. 1975).

safeguards would also apply to any attempt by the state to initiate the involuntary institutionalization of a child. This Court ruled in *In re Gault,* 387 U.S. 1 (1967), that despite the state's *parens patriae* purpose in juvenile delinquency proceedings, due process required a judicial hearing before children could be removed from their homes and placed in juvenile institutions.[5]

Similarly, the right to procedural due process also applies where the commitment is not labeled "involuntary" but where the state is nonetheless an active participant in the institutionalization of children (a "massive curtailment of liberty"), either through its initiation of admission as their guardian or, when the commitment is initiated by parents, through its acceptance of the children and its operation of the facility in which they are placed.[6] Children in mental institutions very often suffer not only loss of liberty but also serious psychic and emotional harm, risks to intellectual and emotional development and stigma greater than that faced by children confined in juvenile detention facili-

[5] *See also In re Winship,* 397 U.S. 358 (1970); *Breed* v. *Jones,* 421 U.S. 519 (1975); *cf. Goss* v. *Lopez,* 419 U.S. 565 (1975). This Court's decision in *Ingraham* v. *Wright,* 430 U.S. 651 (1977), is fully consistent with the principle that due process applies to the deprivation of a child's liberty. While corporal punishment in the public schools was found not to require a prior hearing, the Court nonetheless held that the imposition of corporal punishment implicated a constitutionally protected liberty interest under the Fourteenth Amendment. *Id.* at 672.

[6] This case does not involve parental commitment of children to private mental facilities pursuant to a state statute. Hence, this brief will not address the issue of whether such commitments are within the protection of the Fourteenth Amendment.

ties.[7] "In view of this it would be extraordinary if the Constitution did not require the procedural regularity and the exercise of care implied in the phrase 'due process.' " *In re Gault,* 387 U.S. 1, 27, 28 (1967).[8]

Therefore the critical question before this Court is not whether due process applies, but rather what procedures constitute "due process of law." *Morrissey* v. *Brewer,* 408 U.S. 471 (1972).[9]

II. UNDER THE TEST SET FORTH IN *MATHEWS* v. *ELDRIDGE,* THE PROCEDURES PROVIDED BY GEORGIA CODE SECTION 88-503.1 ARE CONSTITUTIONALLY INADEQUATE.

Under Georgia Code Section 88-503.1, the decision to admit a child who has been "volunteered" for com-

[7] *Amici* do not suggest that the Fourteenth Amendment is applicable simply because an institutionalized child is likely to suffer "grevious loss", *Smith* v. *Organization of Foster Families for Equality and Reform,* 431 U.S. ——, 45 U.S.L.W. 4638, 4644 (1977). Rather, as the district court pointed out, the Fourteenth Amendment applies because the confinement of a child in a mental institution against his will interferes with his right to liberty in the most fundamental and profound sense. J.S. 48a, 49a. *Cf. Humphrey* v. *Cady,* 405 U.S. 504, 509 (1972); *In re Gault,* 387 U.S. 1, 27 (1967).

[8] The fact that commitment to a mental facility is based on the child's need for care and treatment and not on the commission of a specified wrongful act does not change the need for due process protection. An adult whose commitment is grounded on his status as a sexual psychopath or a mentally disabled person is clearly entitled to a hearing as to whether he meets the statutory criteria for the status. *See Specht* v. *Patterson,* 386 U.S. 605 (1967); *cf. Jackson* v. *Indiana,* 406 U.S. 715 (1972). In addition, a decision that a disturbed child needs institutionalization is usually based in part on specific behavior attributed to the child, which may be subject to factual dispute.

[9] *See also, Board of Regents* v. *Roth,* 408 U.S. 564, 566-572 (1972).

mitment by his parent or guardian is made by the superintendent of the mental facility on the basis of a staff interview. No evidentiary hearing is provided.

In *Mathews* v. *Eldridge,* 424 U.S. 319, 335 (1976), this Court identified the factors that must be considered in determining whether such a procedure meets the requirements of due process:[10] first, the potential harm to the individual flowing from an erroneous decision; second, the risk of an erroneous decision under the challenged procedure; and third, the countervailing interest asserted in support of the challenged procedure.

Consideration of these factors makes clear that the present Georgia procedure is constitutionally inadequate.

A. The Decision to Institutionalize a Child Interferes with the Child's Liberty and Development and Presents Substantial Likelihood of Serious Irreversible Harm.

Institutionalization, by its very nature, has a severe impact on a child's liberty. The child is taken from his family and is subjected to the rigid structure and rules of a closed facility, including locked wards, isolation cells, physical and chemical restraints and restriction of contact with the extrahospital community.[11]

[10] *See also, Smith* v. *Organization of Foster Families for Equality & Reform,* 431 U.S. ——, 45 U.S.L.W. 4638, 4646 (1977); *Cafeteria & Restaurant Workers Union* v. *McElroy,* 367 U.S. 886 (1961).

[11] *See, e.g., Price* v. *Sheppard,* 239 N.W.2d 905 (Minn. 1976) (use of electroconvulsive therapy on minors); Mitchell, *Experimentation on Minors: Whatever Happened to Prince* v. *Massachusetts?* 13 Duquesne L. Rev. 919 (1975) (medical experimentation performed on minors in mental institutions). Cf. *Hearings on the Use of Children as Subjects in Biomedical and Behavioral Research before the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research* (April 9, 1976) (Testimony of Dr. Robert Sprague).

Of course, the degree of liberty children enjoy differs from adults', since they are subject in varying degrees to the control of their parents. But there is little question that a child's liberty of movement and how he spends his time is substantially restricted when he moves from home and neighborhood into a mental facility. The change in his situation is often not qualitatively different from that of the delinquent child placed in a rehabilitative facility by the juvenile court, a move which this Court has already circumscribed with hearing procedures.[12]

In addition to restrictions of physical liberty, institutionalization for any substantial period of time can cause other equally serious harms to children. Its impact on their intellectual and emotional development can result in irreversible damage to their future potential as adults. Moreover, the mere fact of institutionalization carries with it a lifelong stigma which may prejudice them in admission to employment, licensing, higher education and access to health benefits.

1. Institutionalization Can Result in Loss of Family and Community Ties.

When a child is institutionalized for any period of time,

> "his world becomes 'a building with white-washed walls, regimented routine and institutional hours. . .' Instead of mother and father and sisters

[12] *See Heryford* v. *Parker,* 396 F.2d 393, 396 (10th Cir. 1968). "It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feebleminded or mental incompetent—which commands observance of the constitutional safeguards of due process."

and brothers and friends and classmates, his world is peopled by guards, custodians, [and] state employees. . . ."

In re Gault, 387 U.S. 1, 27 (1967), quoting Holmes' Appeal, 379 Pa. 599, 616, 109 A.2d 523, 530 (1954). Deprivation of family and community life, however brief and necessary, is inevitably traumatic for both younger children and adolescents.[13] Commitment destroys the "continuity of relationships, surroundings and environmental influences [which] are essential for a child's normal development."[14] Moreover, the committed child is placed in an environment characterized by constant staff turnovers, thus making it difficult if not impossible for him to develop new stable relationships. Dr. Eli C. Messinger described the impact of this dislocation on Plaintiff J.L. as follows:

"One of the things that I noticed about Joey is that he was—he latched onto whoever seemed to offer him what I would call a feeding experience, a nurturing experience, giving experience, at that moment. . . . [I]n an institutional setting because one doesn't have the mother and father to whom one can rely on for nurturance over an extended, really indefinite period of time, one has to make use of whoever is available at the moment. Also,

[13] *See, e.g.,* M. Grob & J. Singer, Adolescent Patients in Transition 115 (1974) [hereinafter Grob & Singer]. A survey of adolescents who had been institutionalized in a private facility of high quality showed that a majority of their families "had a negative view" of the hospitalization. They cited as "added problems which accrued from hospitalization . . . exposure to other sick people, drugs, sex, removal from the community of normal adolescents" and the fact that "the child had irretrievably lost an entire stage of his development." *Id.* at 126, 116.

[14] J. Goldstein, A. Freud and A. Solnit, Beyond the Best Interests of the Child 21 (1973).

one learns that the good guy or the good woman who might be available today might not be available on the next shift or . . . the next week or month, so one takes what one can when one can. I saw a great deal of that mentality in Joey."[15]

Although the potential for grave harm exists when a child is institutionalized for even short periods of time, lengthy institutionalization is particularly deleterious to the maintenance of family ties. It often signifies—or else leads to—formal severance of parental involvement. After the child has been away from home for a substantial period, the "parents have sort of fallen out of love with him" and reintegration into the realigned family circle becomes more difficult.[16] In many cases, admission to a mental institution amounts to a life sentence. According to the Joint Commission on the Mental Health of Children, one-fourth of the children admitted to one state's mental hospitals "can anticipate being permanently hospitalized for the next fifty years of their lives."[17]

Children are particularly adaptable to their environment. These adaptations usually become an integral part of the child's personality. "A child institutionalized for long periods of time may learn and assimilate

[15] A. 211-212.

[16] DeMyer, *New Approaches to the Treatment of Very Young Schizophrenic Children,* in The Mental Health of the Child, 424 (Public Health Service Publication No. 2168, 1971). *See also* Hammond, *Parental Interest in Institutionalized Children: A Survey,* 20 Hosp. & Comm. Psychiatry 338 (1969).

[17] Joint Commission on the Mental Health of Children, Crisis in Child Mental Health: Challenge for the 1970's at 6 (1969) [hereinafter Joint Commission Report].

'institutionally appropriate' behavior, which in turn is . . . [a] handicap if he is to return to his normal environment." [18]

There is, therefore, a definite threat to an institutionalized child of losing his place in and his capacity to adjust to his family and community.

2. INSTITUTIONALIZATION THREATENS THE INTELLECTUAL AND EMOTIONAL DEVELOPMENT OF CHILDREN.

It is widely recognized that institutionalization presents the threat of deleterious long-term effects on cognitive, emotional and social development.[19] Indeed, confinement in an institution frequently produces what is known as "institutional neurosis," a condition characterized by apathy, lack of initiative, loss of individuality and a deterioration in personal habits.[20]

To develop normally, a child must undergo certain basic life experiences at particular stages of his development. For very young children, there is an overwhelming need for a consistent, affectionate "mothering" relationship with one person. Without adequate "mothering," the child never learns to form close personal relationships or to develop inner self controls. As the child grows, he needs individualized responses

[18] Report of the Study Commission on Mental Health Services for Children and Youth at 6 (1973) (A. 904) [hereinafter Georgia Commission Report].

[19] For these reasons many professional child care workers have a "pervasive feeling" that institutionalization should be a last resort. R. Glasscote *et al.*, 35, Children and Mental Health Centers 20 (1372); Joint Commission Report, *supra*, at 269.

[20] R. Barton, Institutional Neurosis (1959) as cited in D. Vail, Dehumanization and the Institutional Career 140-144 (1966).

and guidance in his attempts to master physical, social and intellectual skills. If he is not responded to promptly and positively, he will not continue to strive for mastery of these skills and he may suffer emotional disturbance.[21] A growing child also needs a "wide range of experiences in seeing, hearing, touching, handling and moving" or he will not learn to talk, to develop his intellectual skills or to master conceptualization and abstraction.[22] Further, the preadolescent child needs an increasing involvement with the community, outside of his immediate family environment, if he is to learn to function as a constructive member of society.[23]

In view of these developmental needs, it is significant that studies of young children in institutions document the conclusion that "most infants living in institutions do not get enough mothering in purely quantitative terms." Infant care is typically routinized, the baby "is fed, diapered, lifted up and put to sleep on a schedule that is almost exclusively externally determined." The mother-child communications that form the infant's earliest and often most decisive learning experiences are "reduced to a minimum." [24]

In most institutions there are several different "shifts" of staff each day and the rate of staff turnover is extremely high. In one facility studied, the

[21] J. Bowlby, Child Care and the Growth of Love 60-61 (1953) [hereinafter Bowlby].

[22] Joint Commission Report, *supra* at 321.

[23] Joint Commission Report, *supra*, at 331.

[24] S. Provence & R. Lipton, Infants in Institutions 19 (1962) [hereinafter Provence & Lipton].

children on one ward were cared for by 246 different adults in a three and one-half year period.[25] Under these circumstances consistent "mothering" is an impossibility.

Such deprivation is not limited to infants. Other children as well seldom, if ever, receive the individualized response they need for their experimental forays into physical and mental skill development.

> "The most serious deficiency of the total [institutional] program is the lack of awareness that each child is an individual . . . . The children are herded in groups from one place to another and no opportunity arises for them to be treated as individuals. Individual treatment is, of course, essential for a child to grow into a socially sensitive person."[26]

As one research team observed, "[A]ny attempt to make a personal decision such as is typical of normal childhood will probably cause the individual to be punished because he is deviating from administrative routine."[27]

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[25] N. Hobbs, The Futures of Children 129 (1975) [hereinafter Hobbs].

[26] B. Flint, The Child and the Institution 16 (1966).

[27] H. Leland & D. Smith, Mental Retardation: Present and Future Perspectives 84 (1974) [hereinafter Leland & Smith]; Bowlby, *supra*, at 61:

> "The child is not encouraged to individual activity because it is a nuisance; it is easier if he stays put and does what he is told . . . often the children sit inert or rock themselves for hours together . . . . In these conditions, the child has no opportunity of learning and practising functions which are as basic to living as walking and talking."

Children in institutions are also unlikely to be exposed to the stimuli and challenges a growing child needs. They are often confined to one indoor living unit and one daily period of outdoor recreation. "Nothing is new, nothing is different, therefore nothing is memorable. Life is dull and plodding; an interminable sequence of sameness over and over again."[28]

Finally, life in an institution rarely offers opportunity for integration of a child into community life. The family is the usual "socializing agent" and bridge to community life. Children of a very young age develop marked identification with their kinfolk which assists them in finding a community identity.[29] When they are denied community experiences and involvement, "their behavior as young adults reflects their lack of contact with normal people during their developmental period." Institutionalized children "have as models only other handicapped persons."[30]

There has been extensive documentation of the psychological and developmental harms that beset an institutionalized child or adolescent. These include low scores on intelligence tests, poor progress in school, deficiencies in emotional and social development. These harms accelerate with the length of the institutionalization, the age at which the child was first admitted

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[28] B. Flint, *supra*, at 15.

[29] Elkin, *Agents of Socialization*, in Children's Behavior 360 (Bergman ed. 1968).

[30] Leland & Smith, *supra*, at 86; Glenn, *The Least Restrictive Alternative in Residential Care and the Principle of Normalization*, in The Mentally Retarded Citizen and the Law, (M. Kindred, *et al.*, eds. 1976).

and the impoverished conditions in the institution.[31] Institutionalized infants show marked retardation in intellectual and language development.[32] Moreover, this retardation does not readily disappear even when the infants are placed in foster homes before the age of two.[33] This phenomenon applies to well-staffed nurseries as well as to poorly run state hospitals. "[T]he residential nursery considered as a language laboratory appears to be inferior to a 'good' working-class home."[34]

The harms of institutionalization extend to social and emotional as well as cognitive development. Institutionalized children tend to become "apathetic"[35] and unable to form meaningful relationships with others, or they acquire "affection hunger" characterized by "incessant and insatiable seeking of affection."[36] This

[31] Hobbs, *supra* at 135, 142-143. Of course, in recent years, mental health and mental retardation professionals have learned more about how, given adequate resources, institutions can have more effective habilitation programs. Possibly, in the relatively few institutions which now have such adequate habilitation programs, children would not show such impaired development relative to children who are not institutionalized. Unfortunately, such comparative information is not currently available.

[32] Yarrow, *Maternal Deprivation: Toward an Empirical and Conceptual Reevaluation in Maternal Deprivation* 3, 9-11 (Child Welfare League of America, 1962).

[33] Provence & Lipton, *supra* at 149, 155-156.

[34] Tizard & Joseph, *Cognitive Development of Young Children in Residential Care: A Study of Children Aged Twenty-Four Months,* 11 J. Child Psychology-Psychiatry 177, 185 (1970). *See also* Lagmeir & Matejcek, *Mental Development of Children in Families and in Infant Homes,* 4 Soc. Sci. & Med. 569, 570-573 (1970).

[35] Hobbs, *supra,* at 143.

[36] Yarrow, *supra* at 14.

emotional and social lag, like its cognitive counterpart, typically persists even after the institutionalized infant is removed to a family environment.[37]

It is for these reasons that professionals in the mental health field caution against the institutionalization of a child except when it is absolutely necessary.[38]

The inherent dangers of institutionalization are, moreover, exacerbated for many children because they are placed in substandard institutions, lacking adequate staff, physical facilities and constructive programs designed to improve or cure the child's underlying condition. In 1969 the Joint Commission on the Mental Health of Children[39] reported that "most"

[37] Provence & Lipton, *supra* at 150-155. *See also* Youngleson, *The Need to Affiliate and Self-Esteem in Institutionalized Children,* 26 J. Personality and Soc. Psychology 280 (1973); Tizard & Rees, *The Effect of Early Institutional Rearing on the Behavior Problems and Affectional Relationships of Four-Year-Old Children,* 16 J. Child Psychology-Psychiatry 61 (1975).

[38] "[N]o matter how good a treatment program for children in the state hospital is, hospitalization of an emotionally disturbed child is not the best answer."

The "basic experiences which a child needs in order to grow into an emotionally happy, healthy and productive adult . . . cannot be found in a hospital."

Reiger, *Changing Concepts in Treating Children in a State Mental Hospital,* 1 Int. J. Child Psychotherapy 89, 104, 107 (1972).

"It makes little difference whether the institution is called hospital or school, whether it is supposedly medically oriented or educationally oriented; in either case the child is trained to live in an institutional setting, and thus learns many of the very things that we do not want him to learn."

Leland & Smith, *supra,* at 87.

[39] The Joint Commission on the Mental Health of Children was established by the U.S. Department of Health, Education and Welfare pursuant to amendments to the Social Security Act, July 30,

mental institutions for children are "disgraceful and intolerable." Each year thousands of minors are removed from their homes, schools and communities and confined to hospital wards with psychotic adults or to depersonalized institutions which deliver little more than custodial care. As the Joint Commission stated:

> "Each year, increasing numbers of [children] are expelled from the community and confined in large state hospitals so understaffed that they have few, if any, professionals trained in child psychiatry and related disciplines.
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> * * *
>
> "In most of these hospitals the usual practice is to place the youngsters in wards with adult patients, frequently with those who are in an advanced stage of mental deterioration. These children and youth receive little, if any, therapeutic care, and no provision is made for the continuation of their education. An imprecisely determined number are left to 'rot on the back wards,' condemned to a hopeless life of continuing institutionalization." [40]

In addition to shortages of professional staff, the Commission found untrained attendants, failure to provide

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1965, Pub. L. 89-97, § 231(a)-(d), 79 Stat. 360. It was composed of "representatives of leading national medical, welfare, educational, and other professional associations, organizations, and agencies active in the field of mental health of children." *Id.* § 231(c).

[40] Joint Commission Report, *supra*, at 5 and 269. *Cf. Jackson* v. *Indiana*, 406 U.S. 715, 734-735 n. 17 (1972): "[There are] substantial doubts about whether the rationale for pretrial commitment—that care and treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions." *See also* A. Stone, Mental Health and Law: A System in Transition 21 (1975) ("As one considers the entire law-mental health system, its most tragic faults are to be found in what it does to the young.").

education and recreation and "outmoded facilities" operating on "long abandoned theory," and it concluded pessimistically that "instead of being helped, the vast majority [of children] are the worse for the experience." [41]

Unfortunately, the institutions to which the plaintiffs have been committed are characterized by these same conditions. In 1973, a Study Commission on Mental Health Services for Children and Youth was formed in Georgia. After six months of study of the then five regional hospitals the Commission reported "that State improvement of mental health services to children and youth is *urgently needed.*" (emphasis added) The Commission found that [42]

> "[in] many cases, youth are housed on geographic units with disturbed adults. Staff were concerned that in these units adolescents are continuously confronted with pathological adult behavior patterns at a time in their psychological development when healthy role models are needed to help them develop an individual sense of identity." [43]

The Commission cited a range of problem areas which are statewide in nature.[44]

The Commission urged the development of appropriate and adequate services based upon professional standards, and a State plan, developed with citizen advisory participation, reflecting unmet needs of children and youth. They reported there were no estab-

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[41] *Id.* at 6.

[42] Georgia Commission Report at 9 (A. 906).

[43] *Id.* at c-1.

[44] A. 902.

lished State program standards, no State plan for mental health services to children and youth and few appropriate services both within and without institutions.[45] As the district court found, conditions have not changed since the Commission's report. J.S. 52a.

Given these facts it is not surprising that five of the eight regional hospitals to which children are confined in the State of Georgia have been denied accreditation by the Joint Commission on Accreditation of Hospitals (JCAH).[46] The poor quality of mental facilities available for children both in Georgia and in the country at large only serves to underscore the enormous harm to a child that results from an erroneous decision to commit.

3. Institutionalization Stigmatizes a Child Thereby Causing Him Future Harm.

The adverse effects of commitment do not end when the child is finally released from the institution. Both the record in this case and the professional literature demonstrate the profound stigma associated with being labeled "mentally ill."[47]

> "[B]eing an ex-mental patient is more of a liability than being an ex-criminal in the pursuit of housing, jobs, and friends. Mental patients have for years been regarded with more distaste and less

[45] A. 906.

[46] Testimony of Dr. Douglas Skelton (A. 221, 228). JCAH is a private body which inspects a wide range of medical treatment facilities and certifies them according to professionally accepted standards. JCAH, *Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents* iii (1974).

[47] Testimony of Dr. Eli Messinger, (A. 177).

> sympathy than virtually any other disabled group in our society. . ."[48]

Former mental patients also suffer discrimination in admission into higher education,[49] military and government services and in applications for licenses and health insurance.[50]

[48] Rabkin, *Public Attitudes Toward Mental Illness: A Review of the Literature*, Schizophrenia Bulletin at 10 (Issue #10, Fall 1974). *See also*, Tringo, *The Heirarchy of Preference Toward Disability Groups*, 4 Journal of Special Education 295 (1970), where it was found that of 21 disability groups including exconvicts and alcoholics, the mentally ill ranked lowest in public esteem; J. Nunnally, Popular Conceptions of Mental Health: Their Development and Change 42-51 (1961). It is important to note that the general public associates mental illness with the fact of hospitalization, but does not attach this label to less drastic forms of psychiatric or psychological therapy. *See* Goffman, *Career of the Mental Patient*, 22 Psychiatry: Journal for the Study of Interpersonal Processes 123 (May 1959); Johannsen, *Attitudes Toward Mental Patients: A Review of Empirical Research*, 53 Mental Hygiene 218 (1969); Phillips, *Public Identification and Acceptance of the Mentally Ill*, 56 American Journal of Public Health 755 (1966).

[49] This Court has already acknowledged that short-term suspensions of children from school "could seriously damage the students' standing with their fellow pupils and their teachers as well as interfere with later opportunities for higher education and employment." *See also, In re Gault*, 387 U.S. 1, 23, 24 (1967). Former Secretary of the Department of Health, Education and Welfare, Elliot Richardson, has declared that "inappropriate labelling of children as *delinquent, retarded, hyperkinetic, mentally ill, emotionally disturbed* . . . has serious consequences for the child." Hobbs, *supra*, Preface at ix.

[50] *See*, American Psychiatric Association, Task Force Report 9, Confidentiality and Third Parties 27, 53-59 (1975) ("Attitudes of a large part of our social world are still prejudicial and the livelihood and social well-being of some of our patients can be threatened in reality by . . . disclosures"; rejection by school systems and many government agencies of those with psychiatric histories; use

A record of institutionalization produces negative expectations in those with whom the ex-patient later comes into contact, including teachers and prospective employers.[81] The evidence also suggests that persons with mental disturbances suffer greater rejection from their peers if they seek help in an inpatient psychiatric residence, rather than from a clergyman or a physician or on a psychiatric outpatient basis.[82] Institutionalization in a mental facility may also produce a negative

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of psychiatric information in school records to the detriment of the child). N. Spingarn, Confidentiality, A Report of the 1974 Conference on Confidentiality of Health Records 5 (American Psychiatric Association 1975) (graduate school rejection on basis of a student's history of emotional problems). *See also* The Mentally Retarded Citizen and the Law, *supra*, chs. 6, 8, 10, 11.

There is also evidence that, once hospitalized, a mental patient is more likely in the future to be differentially diagnosed as in need of rehospitalization.

> "Physicians responsible for hospitalization seem, unwittingly, to take this history into account, independent of the number of symptoms and apparently even the severity of the patient's present illness."

Roth, *Some Comments on Labelling*, Bulletin of the American Academy of Psychiatry and the Law (1976) citing Mendel & Rapport, *Determinants of the Decision for Psychiatric Hospitalization*, 20 Arch. Gen. Psychiatry 321 (1969).

[81] *See* Whatley, *Social Attitudes Toward Discharged Mental Patients*, in The Mental Patient: Studies in the Sociology of Deviance 401 (1968). Because of a "lingering social stigma attached to newly discharged patients . . . their social relations are often characterized by social distance, distrust or denial of employment." *See also* Grob & Singer, *supra*, at 117.

[82] Phillips, *Rejection: A Possible Consequence of Seeking Help for Mental Disorders*, in Mental Illness and Social Processes 63 (T. Scheff ed. 1967).

self-image in the child.[83] Frequently a formerly committed individual tends to perceive society's negative response to him as a valid measure of his personal worth. The label becomes a "double-edged blade," causing "him to demean himself and to magnify social ostracism." *In re Ballay*, 482 F.2d 648, 669 (D.C. Cir. 1973).[84]

In the case of a child who is actually in need of commitment to a mental institution, these detrimental effects are the unfortunate price that must be paid to enable the child to overcome his disability. But, where a child is committed unnecessarily, the profound and long-term harm that results is inexcusable.

B. There Is a Substantial Risk of Error in Decisions to Commit Children to Mental Institutions.

1. The Decision to Institutionalize Is Often Made on the Basis of Conflicts of Interest Between the Child and Other Family Members or in Ignorance of the Availability of Alternative Resources.

The manner in which decisions to institutionalize children are made must provide assurances that the child's interest in remaining in the mainstream of family and community life and avoiding developmen-

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[83] One study which interviewed 110 mildly retarded former institutional residents found:

> "All persons interviewed said that their former status had burdened them with a shattering stigma and that they were forced to create elaborate ways of evading recurrent social ostracism—for instance, by rejecting as false the initial diagnosis and inventing ingenious ways to cover real deficiencies."

I Issues in the Classification of Children 214 (N. Hobbs ed. 1975).

[84] *See also* Cumming and Cumming, *On the Stigma of Mental Illness*, 1 Community Mental Health Journal 135, 136 (1965).

tal harms is protected. Institutionalization for mental illness is not, as appellants argue,[55] primarily a medical decision in which parents' interests can be assumed to be in harmony with the children's interest.[56] Rather, too often the decision is based on whether the child's family has sufficient emotional and financial resources to cope with the child's behavior at home and whether the community has sufficient tolerance for his behavior or resources to offer the family as an alternative to institutionalization.[57]

Testimony in the court below emphasized that the mentally ill child's problems are "inextricably re-

[55] Appellants' brief at 14 and 15.

[56] *Cf. Planned Parenthood of Cent. Mo.* v. *Danforth*, 428 U.S. 52, 103, 104 (1976). (Stevens, J. concurring in part and dissenting in part). Justice Stevens referred to the fact that "the most significant consequences of the decision [to abort] are not medical in character . . . . In each individual case factors much more profound than a mere medical judgment may weigh heavily in the scales. The overriding consideration is that the right to make the choice be exercised as wisely as possible."

[57] *See, e.g.*, Lindsey, *Adolescent Pathways to Residential Treatment: The Enforced Expedition*, suggesting that "rather than performing an illness-reduction service, mental hospitals alleviate community and family displeasures through an annoyance-reduction service." *Id.* at 136. The study showed that most adolescent admissions into a public mental hospital resulted from "unmanageable" or "inappropriate" behavior as defined by police, community members or family. *Id.* at 140. The author concluded, "[F]or most of these adolescents the prescription of residential placement is more often the result of a response on the part of social agencies in the adolescent's social world than by the specific nature of the behaviors performed by the adolescent." *Id.* at 143. He warned that "mental illness is distinctly different from physical illness. Mental illness is not just an adolescent's private troubles and personal problem. Rather, it is a label applied to the alleged and inappropriate behavior engaged in by the adolescent. The conflictive nature of this behavior emerges from an analysis of the social environment of the prepatient adolescent." *Id.* at 144.

lated" to the pathology of the family.[58] Some children unwittingly become the "scapegoats" for family hostilities; some parents have hidden agendas and even unconscious motivations for institutionalizing the child. A parent may be mentally ill or under severe psychological stress himself, projecting his own illness onto the child.[59] The Joint Commission Report accurately acknowledged "growing recognition that a child's emotional disturbance is frequently . . . associated with the complex and intricate interpersonal relations within the family and the interactions that the family has with the larger social system."[60]

The motives of parents in deciding on institutionalization for a mentally ill child are not necessarily blameworthy; they may simply reflect priorities for family survival,[61] such as the interests of other children in the family, the mental and physical frustration of the parents, economic strain resulting from the care of the child, the stigma of the handicap itself, or hostility toward the child caused by fatigue and frustration of the parents' success-oriented expectations for the child.[62] But, as the court below and other courts have

[58] Testimony of Dr. Eli Messinger, (A. 163).

[59] Testimony of Dr. Eli Messinger, (A. 163-165), testimony of Dr. Luciano L'Abate, (A. 804-805).

[60] Joint Commission Report, *supra*, at 263.

[61] Grob and Singer, *supra*, at 122 (followup interview of institutionalized minors and their families showed that virtually no parents perceived the hospitalization as resulting in a cure of the child's problems. "Most parents did see the hospitalization serving an ameliorative function, *e.g.*, releasing them of responsibility and of home tensions, and protection of the patient and/or society.")

[62] Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 Notre Dame Lawyer 139-143 (1972).

recognized, these interests compete with those of the institutionalized child.[63]

Institutionalization decisions have been shown to relate more closely to the characteristics of the family than to the severity of the child's condition or to the optimum treatment. Children from broken homes, from homes with substandard incomes, from homes with other physically or mentally ill persons present are disproportionately represented in the institutional population.[64]

Thus, the decision by parents to place their children in a mental institution is too often a decision made in default of knowledge about community-based alternative services and, for complex reasons, unrelated to

[63] *See e.g., Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968); *Saville* v. *Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974); *In re Long*, 25 N.C. App. 702, *cert. denied*, 288 N.C. 241 (1975).

[64] G. Saenger, Factors Influencing the Institutionalization of Mentally Retarded Individuals in New York City 13 (Report to the New York State Interdepartmental Health Resources Board, 1960), 11, 84 (44% noninstitutionalized versus 77% institutionalized children come from broken homes); D. Block & M. Behrens, A Study of Children Referred for Residential Treatment in New York State 43 (Report to the New York State Interdepartmental Health Resources Board 1959) 32-35 (half of institutionalized children came from multiproblem families, half had mentally ill family members); Appell & Tideall, *Factors Differentiating Institutionalized from Non-Institutionalized Referred Retardates*, 73 Am. J. Men. Def. 424, 429 (1968) (37% institutionalized children versus 14% noninstitutionalized children from broken homes; 62% institutionalized versus 22% noninstitutionalized children from impoverished homes). *See also* J.S. 20a., where the opinion of the district court indicated that 50-75% of the children in Georgia mental institutions had no family or were part of "severely dysfunctional" family units.

the best interests of their children.[65] Because the risk of unnecessary confinement of the child is extremely high, such commitments must be accompanied by procedural safeguards designed to ensure the appropriateness of commitment.

2. There Is a Substantial Risk of Error in Recommendations by Mental Health Professionals to Confine Children to Institutions.

Despite the enormous harm to the child that results from an erroneous decision to commit, due process might not require an evidentiary hearing if the likelihood of psychiatric error was relatively slight. In fact, however, there is a very substantial risk of error in recommendations and decisions to confine children to mental institutions.

a. *There Is a Tendency by Mental Health Professionals to Overinstitutionalize Children.*

The tendency of mental health professionals to prescribe institutionalization for persons not in need of

[65] *Cf.* Child Caring: Social Policy and the Institution 112 (D. Pappenfort, et al., eds. 1973):

> "[O]ne thing that is clear from a variety of statistical data is that both the decision to place a child in an institution and the selection of the type of institution for him are dependent to a great extent on factors other than the needs of the child."

See also R. Glasscote, *supra*, at 973, quoting psychiatric program personnel who decided between inpatient and outpatient admissions:

> "Diagnosis itself has minor significance . . . . Rather we look to the criteria of the child's daily living situation at home."

confinement has been widely noted.[66] Various empirical studies have verified it.[67]

Various factors explain the predisposition of mental health professionals to recommend institutionalization where it is not required. First, the tradition of the medical profession dictates erring on the side of ap-

[66] *See, e.g.*, T. Scheff, *Being Mentally Ill: A Sociological Theory* 105-21 (1966); Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 Colum. L. Rev. 897, 900 (1975); Dershowitz, *Psychiatry in the Legal Process: A Knife That Cuts Both Ways*, 4 Trial 29, 32-33 (Feb./March 1968); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Calif. L. Rev. 840, 863-68 (1974); Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Calif. L. Rev. 693, 711-19 (1974); Livermore, Malmquist and Meehl, *On the Justifications for Civil Commitment*, 117 U. Pa. L. Rev. 75, 83-84 (1968); Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events*, 18 J. of Con. Psychology 397 (1954); Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 Yale L. J. 1540, 1553-54 (1975); *People* v. *Burnick*, 14 Cal. 3d 306 (1975); *In re Long*, 25 N.C. App. 702, *cert. denied*, 288 N.C. 241 (1975); Deposition of Dr. Eli Messinger, (A. 171-173).

[67] *See, e.g.*, Rappeport, Lassen and Gruenwald, *Evaluation and Followup of State Hospital Patients Who Had Sanity Hearings*, 118 Am. J. Psychiat. 1078 (1962). The authors studied the progress of 38 persons who obtained release from a state mental institution over the objection of the institution's psychiatrists. After a year or more, nearly half of the 38 had made a satisfactory adjustment to the community, i.e., they had not been rehospitalized, had not been in serious trouble with the law, and were caring for themselves.

See also, Hunt and Wiley, *Operation Baxstrom After One Year*, 124 Am. J. Psychiat. 974 (1968). This followup study conducted after this Court's decision in *Baxstrom* v. *Herold*, 383 U.S. 107 (1966), followed 969 patients who had been detained in maximum security hospitals by the New York Department of Corrections because psychiatrists had determined them to be mentally ill and too dangerous for release or even for transfer to civil hospitals.

parent caution.[68] The profession perceives the consequences of not treating an individual for a suspected illness as being more serious than the consequences of unnecessary treatment. In the case of mental illness the result of undue "caution" can be devastating—unnecessary confinement in a mental institution.

Second, psychiatrists tend to think in terms of psychopathology.[69] They are apt to diagnose mental illness from ambiguous behavior rather than recognizing equally plausible, yet non-pathological explanations for that behavior.[70] An example of finding psychosis where none exists was reported in the study by David Rosenhan.[71] In Dr. Rosenhan's study, eight normal persons presented themselves for voluntary admission at twelve different mental institutions. The only symptom the subjects pretended to exhibit was hearing voices. Beyond this, they acted normally and were truthful in describing themselves and their history. In every instance, the subject was admitted to the hospital with a diagnosis of schizophrenic or manic-depressive psychosis.

Within a year after their transfer to civil hospitals, 147 had been discharged to the community and only 7 had to be recommitted to a prison hospital; Steadman and Keveles, Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-70, 129 Am. J. Psychiat. 304 (1972).

[68] *See* T. Scheff, *supra*, at 105-21; Ellis, *supra*, at 865-66; Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara L. Rev. 379, 385 (1973).

[69] S. Shah, *Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior*, 53 Mental Hygiene 21, 26 (1969).

[70] Kumaska and Gupta, *Lawyers and Psychiatrists in the Court: Issues in Civil Commitment*, 32 Md. L. Rev. 6, 34 (1972).

[71] D. Rosenhan, *supra*, n. 68.

Rosenhan described one of his subjects as having

> "had a close relationship with his mother but was rather remote from his father during early childhood. During adolescence and beyond, however, his father became a close friend, while his relationship with his mother cooled. His present relationship with his wife was characteristically close and warm. Apart from occasional angry exchanges, friction was minimal. The children had rarely been spanked." [72]

But on the basis of the same information the case summary prepared by the institution portrayed a mentally ill individual:

> "This white 39 year-old male . . . manifests a long history of considerable ambivalence in close relationships, which begins in early childhood. A warm relationship with his mother cools during his adolescence. A distant relationship to his father is described as becoming very intense. Affective stability is absent. His attempts to control emotionality with his wife and children are punctuated by angry outbursts and, in the case of children, spankings. And while he says that he has several good friends, one senses considerable ambivalence embedded in those relationships also . . . ."

Third, erroneous decisions *not* to admit a child are more likely to come to the attention of mental health professionals than erroneous decisions *to* admit. When an individual is erroneously committed, subsequent "normal" behavior will be attributed to the positive effects of institutionalization rather than to a mistaken commitment. On the other hand, when an individual is mistakenly released, that error is likely to come to the

[72] *Id.* at 387.

attention of the admitting psychiatrist when, as sometimes occurs, the person is referred again for possible commitment. In sum, mental health professionals become aware of their mistakes only when they deny admission, and this further inclines them to a decision to admit in future doubtful cases."

Fourth, by erring on the side of institutionalization rather than outpatient care, the mental health professional avoids the possibility that he or the institution will be held responsible, or even liable, if the child should cause harm to himself or others after institutionalization has been denied.[74] There is no comparable risk in the case of mistaken commitments."

Fifth, institutional personnel have knowledge of and confidence in the benefits of institutionalization, while minimizing some of its potential harms. Moreover, they frequently lack knowledge of the availability and desirability of community-based facilities or other possible outpatient alternatives. Familiarity with just one mode of treatment increases the likelihood of a recommendation of admission.

Finally, mental health professionals are frequently influenced by the admission policies of their institution. In the mental health field, more often than in general medicine, it is institutional policy rather than clinical

[73] A. Dershowitz, *supra*, at 32-33; Note, *The Role of Counsel in the Civil Commitment Process*, *supra*, at 1554.

[74] *Cf. Hicks* v. *United States*, 511 F.2d 407 (D.C. Cir. 1975); *Underwood* v. *United States*, 356 F.2d 92 (5th Cir. 1966); *Fair* v. *United States*, 234 F.2d 288 (5th Cir. 1956).

[75] *See* A. Dershowitz, *supra*, at 32-33; Bazelon, *supra*, at 400; Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, *supra*, at 1554.

necessity that determines which children will be admitted and what treatment will be offered."[76]

b. *Psychiatric Diagnoses Are Unreliable*

Appellants assert that there exists a high degree of reliability in psychiatric diagnoses." They contend that there is little evidence that psychiatry is an "inexact science."[77] Their contentions are incorrect. As the Chief Justice recently pointed out in *O'Connor* v. *Donaldson,* 422 U.S. 563, 584 (1975) (concurring opinion), "There can be little responsible debate regarding the uncertainty of diagnosis in this field and the tentativeness of professional judgment." Another court found,

> "Psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession. It must be conceded that psychiatrists still experience considerable difficulty in confidently and accurately diagnosing mental illness."[78]

People v. *Burnick,* 14 Cal.3d 306, 326-27 (1975)."[79]

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[76] Richman and Pinsker, *Utilization Review of Psychiatric Inpatient Care,* 130 Am.J.Psychiatry 900, 901 (1973). *See also* Mendel and Rapport, *Determinants of the Decision for Psychiatric Hospitalization,* 20 Arch.Gen.Psychiatry 321 (1969); Rabiner, *et al., The Assessment of Individual Coping Capacities in a Group Therapy Setting,* 45 Am. J. Ortho. 399 (1975) ("few clinical decisions in psychiatry are as difficult to make as those involving hospitalization.").

[77] Brief for Appellants at 19.

[78] *Id.* at 18.

[79] *See also,* testimony of Dr. Luciano L'Abate:

> "I am perfectly aware of the fallibility of our diagnostic labels, our own diagnostic tests, and in many cases our tests that we use in clinical psychology are not better than the criteria we use, which are mostly psychiatric diagnosis, and [I] realize that any time we have that kind of criteria in our tests they are really not very good."

(A. 805, 806). *See also, In Re Ballay,* 482 F.2d 648, 665 (D.C. Cir. 1973); Ennis and Litwack, *supra,* at 719. *Cf. Blocker* v. *United States,* 288 F.2d 853, 869, n. 28 (D.C. Cir. 1961) (Burger, J., concurring).

It is clear that diagnosis of mental illness is an area of uncertainty and consequent high risk of error.

c. *Decisions to Confine Children to Mental Institutions Are Frequently Made Without Adequate Information or Adequate Exposure to the Child.*

In the context of evaluating children whose commitment to a mental institution is proposed, the likelihood of error is exacerbated by the paucity of information on which commitment decisions are frequently based.

A mental health professional should have as much knowledge as possible of a child's situation in order to decide whether to institutionalize the child.[80] The reason for this is that a child is likely to experience deep anxiety at the first clinical interview and is therefore unlikely to place in the mental health professional the trust and confidence required for a successful evaluation.[81] In addition, children often experience great fluctuations in behavior over short periods of time,

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[80] S. Chess, An Introduction to Child Psychiatry 47 (2nd ed. 1974); Group for the Advancement of Psychiatry, *The Diagnostic Process in Child Psychiatry,* 313 in 3 Reports and Symposiums, Report No. 38 (1957); T. Scheff, *supra,* at 174. The Menninger Foundation recommends that evaluation be conducted by a team of specialists rather than by a lone psychiatrist. The Menninger Foundation Children's Division, *Disturbed Children: Examination and Assessment Through Team Process* (1969).

[81] J. Simmons, Psychiatric Examination of Children 1 (2nd ed. 1974); Group for the Advancement of Psychiatry, Report No. 38, *supra,* at 338-42.

particularly in different settings. Adolescence is normally a time of emotional turmoil, behavioral excesses and rapid change. One can expect alterations and fluctuations in behavior.[82]

Psychiatric or psychological judgments on children whose commitment is sought, however, are typically based on a single interview in a strange setting under abnormal stress. In such instances, the mental health professional will have difficulty in gaining the child's confidence and may indeed be hostilely perceived as an agent of the parents; he will rarely be able to make a thorough evaluation or prediction of the child's future behavior from such an interview.[83]

Moreover, confinement decisions are based, to a considerable extent, upon information provided by the same parents who are seeking commitment of their children. In fact, such information may be the single most important source of data provided to evaluating professionals.[84] And it appears that mental health

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[82] *See* Ennis and Litwack, *supra*, at 723-24; T. Scheff, *supra*, at 174.

[83] *See*, Lourie & Rieger, *Psychiatric and Psychological Examination of Children*, in 2 American Handbook of Psychiatry 19 (S. Arieti ed. 1974).

> "From the child's viewpoint, his degree of cooperation with the examiner will be very different if he feels the examiner is a benevolent adult, interested in his side of any reported troubles and understanding of his worries, as against his perception of a demanding, punitive, authoritative figure who has the power to recommend significant changes in his way of life . . . . His approach to the examination may limit the amount of information available to the examiner, or obscure his assets and conflict-free areas of functioning, or give a distorted picture of his functioning in other situations."

[84] A. 167.

professionals tend to believe parents' accounts of deviant behavior of their children even if those accounts are inconsistent with their direct observations of the child.[85]

In light of the conflicts of interest between the child and other members of the family and the unreliability of diagnostic techniques, there is a serious risk of error in the Georgia "voluntary" commitment process. This risk of error, coupled with the grave and irreversible harm that can result from an erroneous decision to institutionalize, requires an evidentiary hearing, the nature of which will be explored in Section III, *infra*.

C. The Countervailing Interests of the State Do Not Outweigh the Child's Need for an Evidentiary Hearing.

1. The Interest of the State Acting as Guardian for the Child Does Not Outweigh the Child's Need for an Evidentiary Hearing.

Initially, it is important to emphasize that in many cases there is no parent involved in the decision to commit a child. As the court below found, parental consent for the commitment is provided, in these cases, by the state welfare department acting as guardian or standing *in loco parentis* to the child.[86]

When a child is placed in a mental facility by a state guardian rather than by parents, the constitutionally protected interests of family autonomy are not relevant. The situation is indistinguishable from cases in which the state initiates involuntary commitment proceedings against adults or children. *Cf. In re Gault*,

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[85] A. 168.

[86] J.S. 5a, 6a, 39a.

387 U.S. 1 (1967)."[87] And the threats of harm to institutionalized state wards are, if anything, greater than to children admitted by natural parents. State wards are denied both the oversight of natural parents as to their treatment inside the institution and the bridge of their family to the normal world outside the institution. They tend to remain in hospitals longer due to the pervasive lack of adequate community facilities to treat and house them on discharge."[88]

As Dr. John P. Filley, Director of the Office of Child and Adolescent Mental Health Services, testified: "The [welfare department] takes the child to the hospital and says, 'Now, it's off our hands.' They're beseiged with oversized case loads and so on. . . ."[89]

Therefore a state agency should not be permitted to authorize commitment of a child to a mental institution without the check provided by a hearing procedure.

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[87] State involuntary commitment statutes which require evidentiary hearings can be invoked against children as well as adults. The state may also invoke neglect jurisdiction when it believes that a parent is unjustifiably withholding needed psychiatric treatment from his child. Neglect proceedings, of course, would require a hearing in which the parents (and usually the child) can contest the need for residential treatment.

[88] One of the named plaintiffs in the present case had been in seven foster homes as a neglected child; at age eight he was placed in the state mental hospital. He remained there for five years despite official predictions that he "will only regress if he does not get a suitable home placement, and as soon as possible." (J. S. 6a). *See also,* D. Block & M. Behrens, *supra,* at 16-17, 32-35 (40% of institutionalized children had lived in four or more different homes or institutions prior to admission; less than one-fourth were living in their natural homes at the time of admission).

[89] A. 101.

2. THE INTEREST OF THE STATE IN PRESERVING FAMILY AUTONOMY DOES NOT OUTWEIGH THE CHILD'S NEED FOR AN EVIDENTIARY HEARING.

The primary justification offered by the state in support of its "voluntary" commitment statute is the state's interest in preserving family autonomy. However, an evidentiary hearing is not inconsistent with the legitimate interests of parents. Families often feel ambivalent and helpless about an emotionally disturbed child; they are driven to institutionalization because they do not know what else to do, and are genuinely searching for a resolution that will allow their child to remain with them. In *Martin M.* v. *Shephard* (D. Conn. No. H-75-130), for example, a father testified as follows concerning his commitment of his son:

> Q. During the year Michael was [in the Hospital] did you, as his parent feel that it was an appropriate place for him to be?
> A. No way, no way.
> Q. Why not?
> A. The conditions were deplorable.
> . . .
> Q. Why did you sign him in the hospital?
> A. We had no other recourse, none.

Testimony of Mr. Karl K., Transcript at 7.[90]

In contrast to the present system for admissions, an evidentiary hearing would provide parents with an opportunity to explore alternatives to institutionalization which would help to preserve the integrity of the family. *See* pp. 50-51, *infra.*

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[90] *Martin M.* is one of several cases presently pending in the district courts challenging the constitutionality of "voluntary" commitment statutes.

Moreover, as *amici* have noted at p. 31 *supra*, some parents attempt to institutionalize their children for reasons which are not consistent with the best interests of the child, *e.g.*, familial conflict, family priorities or other motives not related to the child's need for institutionalization. In some cases, they act unwittingly; in other cases they do not.

As the court below pointed out:

> "Unfortunately, as the evidence indicates there are some parents who abuse [the] authority [to commit] and who under the guise of admitting a child to a mental hospital actually abandon their child to the state. . . . [S]ome still look upon mental hospitals as a 'dumping ground.'"[91]

The case of J.L. is illustrative. It was stipulated that this child was hospitalized because his mother was concerned that he was adversely affecting her relationship with her second husband and their child.[92] Following her consent to J.L.'s commitment, she abandoned him and the institution thereafter was forced to deal with the state welfare agency in matters regarding J. L.[93]

Virtually every lower court that has considered the issue has found that with respect to the commitment of a child, there is a significant chance that parents may be acting against the interests of their children.[94]

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[91] J.S. 50a.

[92] Stipulation of Fact, Exhibit #2-B-2; Mess. Dep. at A. 96.

[93] *Id.*

[94] *See, e.g., Bartley* v. *Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded*, 431 U.S. ——, 45 U.S.L.W. 4451 (1977); *Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968); *Saville* v. *Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974); *New York Association for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973); *Horacek* v. *Exon*, 357 F. Supp. 71, 74 (D. Neb. 1973); *In re Henry G.*, 28 Cal. App. 3d 276, 285 (2nd Dist. 1972); *In re Lewis*, 51 Wash. 2d 193, 200-01 (1957); *In re Sippy*, 97 A.2d 455, 459 (Mun. Ct. App., D.C. 1953); *In re Wretlind*, 225 Minn. 554, 561-62 (1948). The Chief Justice has advised of "the need to make civil commitment difficult, recognizing the dangers of relatives 'farming' out their kindred into mental institutions for motives not always worthy." *Kent* v. *United States*, 401 F.2d 408, 416 n. 4 (D.C. Cir. 1968) (Burger J., dissenting).

Amici acknowledge the special relationship that exists between parent and child. *See, e.g., Smith* v. *Organization of Foster Families for Equality and Reform*, 431 U.S. ——, 45 U.S.L.W. 4638 (1977); *Wisconsin* v. *Yoder*, 406 U.S. 205 (1972); *Meyer* v. *Nebraska*, 262 U.S. 390 (1923). Historically, however, limitations on parental authority over the lives of their children have been recognized in the law.[95] And, although parents ordinarily have the primary role in decisions affecting their children, when the interests of the child may conflict with those of the parents, independent representation for the child is required. *See, e.g., Prince* v. *Clark*, 81 Mich. 167, 170-71 (1890). Therefore, courts have often appointed independent guardians for children and have refused to allow parents to donate their children's organs;[96] alienate their chil-

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[95] *See generally*, 1 W. Blackstone, Commentaries 452-53, 465-66; J. Story, Commentaries on Equity Jurisprudence, Chapter 34 (1835); J. Woerner, A Treatise On the American Law of Guardianship of Minors and Persons of Unsound Mind § 14 (1897).

[96] *See, e.g., In re Guardianship of Pescinski*, 67 Wis. 2d 4, 226 N.W.2d 180 (1975); *Hart* v. *Brown*, 29 Conn. Sup. 368, 289 A.2d 386 (1972); *Strunk* v. *Strunk*, 445 S.W.2d 145 (Ky. 1969); *In re Richardson*, 284 So.2d 185 (La. App.), *cert denied*, 284 So.2d 338 (S. Ct. La. 1973).

dren's property;[97] compromise their children's injury claims;[98] withhold essential medical treatment from their children;[99] and authorize the sterilization of their children.[100]

In *Prince* v. *Massachusetts,* 321 U.S. 158 (1944), this Court pointed out that although "the custody, care and nurture of the child reside first in the parents," parental rights are not "beyond limitation." *Id.* at 166. In *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976), this Court held that a parent may not be granted an absolute veto over the decision of a minor child to secure an abortion. Most significantly, in *Bellotti* v. *Baird,* 428 U.S. 132 (1976), the Court strongly indicated that a statute that permitted a child to obtain judicial approval for an abortion, where parental approval was withheld, would pass constitutional muster. Thus, the Court refused to uphold absolute parental control over a decision vital to the life of a minor, but implied that,

[97] *See generally,* 1 W. Blackstone Commentaries 452-53, 465-66; J. Kent, 4 Commentaries on American Law 185-89 (1830); *see, e.g., Martorell* v. *Ochoa,* 276 F.99 (1st Cir. 1921); *In re Schultz Estate,* 374 P.A. 459, 98 A.2d 176 (1953).

[98] *See, e.g., American Mutual Liability Insurance Co.* v. *Volpe,* 284 F.75 (3rd Cir. 1922); *White* v. *Osborne,* 251 N.C. 56, 110 S.E. 2d 449 (1959); *Loesch* v. *Vassiliades,* 17 N.J. Super. 306, 86 A.2d 14 (1952).

[99] *See, e.g., Jacobson* v. *Massachusetts,* 197 U.S. 11 (1944); *Green Appeal,* 448 Pa. 338, (1972), *appeal after remand,* 452 Pa. 373, (1973); *In Re Sampson,* 65 Misc. 2d 658, 641 (Fam. Ct.), *aff'd,* 37 A.D. 2d 668, (1972); *In Re Carstairs,* 115 N.Y.S. 2d 314 (Dom. Rel. Ct. 1952).

[100] *See, e.g., A.L.* v. *G.R.H.,* 325 N.E.2d 501 (Ct. App. Ind. 1975); *In re M.K.R.,* 515 S.W.2d 467 (Mo. 1974); *Frazier* v. *Levi,* 440 S.W. 2d 393 (Civ. App. Tex. 1969).

where there was disagreement, it could be properly resolved through a hearing procedure. That is exactly the result sought by plaintiffs here, in the context of a proposed civil commitment.

Given the possibility for error and for basic conflicts of interests, this Court should not permit parental foreclosure of a child's right to be heard in connection with a decision as crucial to his life as commitment to a mental institution.

3. The Fiscal and Administrative Concerns of the State Do Not Outweigh the Child's Need for an Evidentiary Hearing.

There are over half a million admissions for inpatient treatment of psychiatric disorders made annually.[101] Evidentiary hearings are routinely accorded to adults who resist commitment and to children whose parents do not consent to commitment, and the states have not found the right to an evidentiary hearing a great fiscal or administrative burden. Extending that right to all children would result in little additional cost.

In Georgia, for example, only 154 children were confined in institutions pursuant to voluntary procedures on January 31, 1976. Nationally, only 9 percent of those receiving inpatient treatment are under 18 years of age.[102] One out of every three of these children is now committed on an involuntary basis pursu-

[101] National Institute of Mental Health, Statistical Note 90, Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, U.S. 1971, Table 1 (1973).

[102] *Id.*

ant to an evidentiary hearing because his parents have objected to hospitalization.[103] Moreover, of the adults confined in state and county mental institutions, 52.9 percent have waived a hearing and committed themselves voluntarily [104] and, presumably, a substantial proportion of the children whose parents have consented would, after consultation with counsel, waive their hearings. Thus, the recognition of the hearing rights of children will result in only a minimal increase in the number of civil commitment hearings conducted. Moreover, as an erroneous commitment imposes a substantial unnecessary burden on the state in the form of costly inpatient care, an additional screening mechanism is likely to reduce overall costs to the state.

III. DUE PROCESS REQUIRES THAT CHILDREN SUBJECT TO INSTITUTIONALIZATION BE AFFORDED AN EVIDENTIARY HEARING.

The procedures required by the due process clause depend on "the need for and usefulness of the particular safeguard in the given circumstances. . . ." Friendly, *Some Kind of Hearing,* 123 U. Pa. L. Rev. 1267, 1278 (1975). As *amici* have demonstrated, the present "voluntary" commitment procedure fosters erroneous decisions to confine children to mental institutions which in turn result in serious harm to these children. An evidentiary hearing would substantially reduce the possibility of such erroneous decisions and consequent harm. *Cf. Mathews* v. *Eldridge,* 424 U.S. 319, 335

[103] This calculation is based on nationwide data on state and county mental hospitals reported in National Institute of Mental Health, Statistical Note 105, Legal Status of Inpatient Admissions to State and County Mental Health Hospitals, U.S. 1972, Table Ia (1972).

[104] *Id.*

(1976). While *amici* maintain that, in committing children to mental institutions, there is an indispensable need for an evidentiary hearing, we will not address here such issues as the forum for the hearing (*i.e.,* judicial or administrative), the applicability of formal rules of evidence and burden of proof required. The district court's judgment properly affords the Georgia legislature an opportunity to enact legislation addressing these issues. However, *amici* submit that any hearing procedure adopted must contain, at least, the minimum safeguards that have traditionally been required in cases involving the deprivation of liberty.[105] These include a hearing before an impartial officer with due notice,[106] counsel [107] and the opportunity to present and cross-examine witnesses.[108] These safeguards are

[105] *See, e.g., In re Gault,* 387 U.S. 1 (1967).

[106] Without adequate notice the right to a hearing is of little significance. *Mullane* v. *Central Hanover Trust Co.,* 339 U.S. 306, 314 (1950). Notice should include a statement of the factual and diagnostic bases for the proposed commitment, so that an adequate response can be prepared. *Cf. In re Gault,* 387 U.S. 1, 33 (1967).

[107] The value of counsel is demonstrated by a study by Wenger and Fletcher. They monitored nearly 100 commitment hearings in one court and found that in 91 percent of the cases in which only the psychiatrist, respondent and referee were present, the psychiatrist recommended commitment. But in only 26 percent of the cases in which counsel represented the respondent, was commitment recommended. Significantly, of respondents *without* counsel, 10 of 15 whom the authors judged not to be in need of commitment and all 25 who were thought to be borderline cases, were committed. Wenger and Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions,* 10 J. of Health and Soc. Beh. 66, 68-71 (1969). *See also* Gupta, *New York Mental Health Information Service: An Experiment in Due Process,* 25 Rutgers L. Rev. 405, 437-38 (1974).

[108] In *Specht* v. *Patterson,* 386 U.S. 605, 610 (1967), the Court held that persons have the right to present evidence and confront

provided in most state statutes in connection with involuntary commitment proceedings,[109] and have been uniformly held to be constitutionally required by both state and federal courts.[110]

Of these minimum safeguards, the right to counsel is perhaps the most important. The presence of counsel will vastly improve the range and quality of the data that are brought to bear on the commitment decision. In addition to the likelihood that counsel will secure better information from the child, he will be in a position to obtain other relevant data that may not be volunteered by the parents, such as information relating to parental abuse of the child or attempts to commit other children of the family. In addition, counsel can secure and present the opinions of a psychiatrist not associated with the institution with regard to the need for confinement.

The presence of counsel would also facilitate an independent opportunity to consider alternative treat-

witnesses in commitment hearings held under the Colorado Sex Offenders Act. These rights are no less important here. While the right to appear personally is also essential if the juvenile is to have a fair opportunity to explain his behavior, there may be circumstances in which the absence of the child at the commitment proceedings may serve his best interest. Thus, we would suggest that the right to appear personally may be waived, either by the juvenile or by the child's counsel, and that such a waiver should be accepted by the hearing officer upon a finding that the child appears too ill to attend the proceedings.

[109] *See, e.g.*, 50 Pa. Stat. Ann. § 4406; D.C. Code § 21-541; Cal. Welf. and Inst'ns Code § 5300-05; Mo. Stat. Ann. § 202.807; Rev. Code Wash. Ann. § 71.05. 310.

[110] *See, e.g., Barry* v. *Hall*, 98 F.2d 222, 225-26 (D.C. Cir. 1938); *Suzuki* v. *Quisenberry*, 411 F. Supp. 1113, (D. Haw. 1976);

ment modes.[111] In this respect, social workers or other treatment professionals could be of assistance at the hearing.[112] In some cases, counsel may locate alternatives to institutionalization to which the parents may agree in advance of the hearing, thereby obviating the need for the commitment proceeding altogether.

Amici believe that an evidentiary hearing is not required when there is agreement among the parties regarding the appropriateness of institutionalization.

Doremus v. *Farrell*, 407 F. Supp. 509 (D. Neb. 1975); *Kendall* v. *True*, 391 F. Supp. 413, 419 (W.D. Ky. 1975) (three-judge court); *Bell* v. *Wayne County General Hospital*, 384 F. Supp. 1085, 1091 (E.D. Mich. 1974) (three-judge court); *Lessard* v. *Schmidt*, 349 F. Supp. 1078, 1090 (E.D. Wis. 1972) (three-judge court), *remanded on other grounds*, 414 U.S. 473, *redecided*, 379 F. Supp. 1376 (1974) *remanded on other grounds*, 421 U.S. 957 (1975) *redecided*, 413 F. Supp. 1318 (1976); *Dixon* v. *Attorney General*, 325 F. Supp. 966, 974 (M.D. Pa. 1971) (three-judge court); *State ex rel. Fuller* v. *Mullinax*, 364 Mo. 858, (1954); *State ex rel. Hawks* v. *Lazaro*, 202 S.E.2d 109 (W. Va. 1974); *cf. Specht* v. *Patterson*, 386 U.S. 605, 608 (1967); *Minnesota ex rel. Pearson* v. *Probate Court*, 309 U.S. 270 (1940).

[111] "In New York City for example, where counsel-advocates work within the admitting hospitals, one of their principal functions has been to seek alternatives to hospitalization satisfactory to their clients (and to the hospital as well) so that long-term hospitalization together with the disabilities and dependencies it involves can be avoided." Andalman and Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic and A Proposal*, 45 Miss. L.J. 43, 47 (1974).

[112] *See, e.g.*, Ga. Code Ann. § 24A-601 to -02 which provides for a probation officer to assist juvenile courts in finding alternative placements for children under their jurisdiction, and Mich. Stat. Ann. § 14.800(469)(2), requiring reports to be filed with the court in the course of civil commitment hearings by agencies or individuals knowledgeable about alternative treatment programs in the person's home community.

However, the susceptibility of the child to professional or parental pressure to acquiesce to commitment suggests the importance of access to counsel before the child is permitted to waive his right to a hearing.[113] Without counsel such a waiver is likely to be the product of "fantasy, fright or despair," *In re Gault,* 387 U.S. 1, 55 (1967), rather than an "intentional relinquishment or abandonment" of a fully known right. *Johnson* v. *Zerbst,* 304 U.S. 458, 464 (1938).

In non-emergency cases evidentiary hearings should precede the commitment, just as they do in cases of adults. In these situations, no harm can result from the brief delay caused by a pre-commitment hearing. But children who are found at a hearing not to be in need of commitment will be spared the deprivation of liberty and the harm they would have suffered as a result of mistaken institutionalization pending a post-commitment hearing. A child's sense of time is such that even a few days in a mental institution can seem a lifetime.[114]

Indeed, if a child is permitted to remain at home pending the hearing, the crisis precipitating institutionalization may even diminish or disappear.[115]

Further, the literature suggests that pre-commitment hearings are preferable, in that post-commitment examinations and hearings increase the likelihood of decisions to commit.[116] This may be due to the impact on

[113] *Cf. Gallegos* v. *Colorado,* 370 U.S. 49, 54 (1962).

[114] A. 178.

[115] A. 179.

[116] *See* Babigian, Gardner, Miles and Romano, *Diagnostic Consistency and Change in a Follow-up Study of 1,215 Patients,* 121 Am. J. Psychiat. 395, 897 (1965).

the individual of confinement with persons who are seriously disturbed. *Cf. United States ex rel. Schuster* v. *Herold,* 410 F.2d 1071, 1078 (2nd Cir. 1969).

Amici respectfully submit that evidentiary hearings would be of great value to children subject to confinement in mental institutions. The evidentiary hearing can fulfill a therapeutic purpose for both parents and children by reviewing the reasons which allegedly justify hospitalization, whether the treatment the child needs can be provided outside of the institution,[117] what treatment the child will actually receive inside the institution,[118] how long he is expected to be institutionalized, whether and when his natural parents are willing and able to receive him back into their home, and what the child's desires are in the matter. All of these factors would be relevant in deciding whether the child is in fact mentally ill and "suitable for treatment," as the Georgia statute specifies.

With a hearing mechanism in place, the choice need not be between institutionalizing a child and returning him to a hostile and helpless family.[119] The decision-

[117] *See also,* A. Stone, Mental Health and Law: A System in Transition 12-14 (1975). Professor Stone argues that in our society institutionalization is generally overused because of the incorrect assumption (or perhaps hope) that "technical" assistance is available when often such expertise is lacking. As a result, we tend to seek scientific solutions where humane care and responsibility are what is needed. Thus, Stone urges a return to family responsibility, rather than the increased use of institutionalization.

[118] Thus, if the institution is substandard or not substantially in compliance with accreditation standards, or not equipped to administer the treatment or training the child needs, the child should not be institutionalized there.

[119] Experts agree that the majority of children presently institutionalized could be treated in the community if sufficient programs

maker in such a hearing can explore the family situation. He may arrange appropriate treatment for the child and/or the family. When only the child is institutionalized, the family's critical role in the treatment process is too often neglected.[120] A hearing officer can also order a thorough review of existing community alternatives. He can insist that the child be provided with the services by public agencies when the family has been frustrated by bureaucratic delays. Hearings can also satisfy a child's inherent sense of fairness and his need to be heard when he feels strongly that he is being dealt with unjustly.[121] Even in those cases where

existed. Joint Commission Report, *supra*, at 266-267. (1) Daytime and partial-hospitalization programs have proven successful for many mentally handicapped children as an alternative to institutionalization. *See, e.g.*, Fenichel, *A Day School for Schizophrenic Children*, 30 Am. J. Ortho. 130 (1960); R. Glasscote, Partial Hospitalization for the Mentally Ill (American Psychiatric Association and National Association for Mental Health Joint Information Service (1969). (2) Community services for the families of these children have also reduced the need for institutionalization. M. Gula, Child Caring Institutions: Their New Role in the Community Development of Services 19 (HEW 1958). (3) Specialized foster care programs for mentally handicapped children have been established in several states. Wolfensberger, *A New Approach to Decision-Making in Human Management Services*, in Changing Patterns in Residential Services for the Mentally Retarded, *supra*, at 379 (1969); Simmons, *et al.*, *Natural Parents as Partners in Child Care Placement*, 54 Social Casework 224-232 (1973). (4) Finally, group homes provide a substitute for mentally handicapped adolescents. M. Gula, Agency Operated Group Homes 1 (HEW 1964); Mosher, *et al.*, *Soteria: Evaluation of a Home-Based Treatment for Schizophrenia*, 45 Am. J. Ortho. 465 (1975).

[120] Joint Commission Report, *supra*, at 112-113, 263.

[121] *Cf. In re Gault*, 387 U.S. 1, 26 (1967).

> "[T]he appearance as well as the actuality of fairness, impartiality and orderliness—in short, the essentials of due process—may be a more impressive and more therapeutic attitude so far as the juvenile is concerned."

hospitalization is necessary, the hearing can relieve parents of the burden of unilateral action. And a hearing may improve the relationship between the child and the professional therapist. Once he has had a full hearing, the child may become more cooperative in the treatment plan. The therapist will perhaps no longer be perceived as a co-conspirator with the parents in committing the child.

Several studies suggest that an opportunity for juveniles to contest institutionalization at hearings will not interfere with therapy. Encouraging active participation of the patient in decision-making about his own future is a tenet of psychotherapy.[122] Adolescent as well as adult mental patients very often have a realistic notion of whether they need hospitalization.[123] And they have apparently exercised their existing limited rights to object to hospitalization in a way that has not

[122] *See, e.g.*, Tucker & Maximen, *The Practice of Hospital Psychiatry: A Formulation*, 130 Am. J. Psychiatry 889 (1973).

> "In the design of a hospital program it is . . . essential to create an atmosphere that encourages patients to take active responsibility for themselves and others. In other words, instead of being the passive recipients of the staff's therapeutic efforts, the patients should assume the role of change agents."

[123] In one study, patient and staff judgments agreed on the avoidability of hospitalization in two-thirds of the cases studied if alternative treatment were available in the community. This ratio was not significantly different for adolescent patients (over 14) than for adults. The study concluded:

> "Judgments made by patients, even though they are acutely more disturbed, are much more valid . . . than might have been expected. . . . The clinical significance of this is that the psychiatrist deciding upon admission versus alternative treatment can validly take into account the opinion of the patient."

Lipsius, *Judgments of Alternatives to Hospitalization*, 130 Am. J. Psychiatry 892, 895 (1973).

been unduly disruptive of hospital routine.[124]

In sum, providing an evidentiary hearing to children subject to confinement in mental institutions can help to decrease unnecessary and damaging institutionalization [125] and to bring to bear on the unfortunate situation of emotionally disturbed children the attention and community resources they require.[126]

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[124] Meisel, *Due Process in the Civil Commitment of Children*, 10 Psychiatric Spectator 5-6 (1975).

[125] The Department of Health, Education and Welfare cites studies showing only one-third of the children in St. Elizabeths Hospital and 20 Texas mental hospitals need hospitalization. National Institute of Mental Health, Statistical Note 115, Children in State Mental Hospitals, 4 (1973).

[126] *Amici* have documented the serious harms attendant upon institutionalization of children and the unreliability of parental and psychiatric decisions concerning its necessity. For these reasons, children must be accorded an evidentiary hearing to determine the need for institutional commitment. The harm is such that children must be protected even for confinements of short duration. At the same time, however, *amici* recognize the legitimate interests of conscientious parents and their professional consultants in meeting the need for short-term psychiatric observation and diagnosis of emotionally disturbed children.

In *amici*'s view, the proper balance of the child's and parents' interests would allow parents of younger children to place them in mental institutions for observation and diagnosis for a brief period, *e.g.*, one week, when it is not possible to conduct an evaluation on an outpatient basis. Even under such circumstances, however, it is imperative that safeguards exist to reduce the potential harm to the growing child which stems from even short-term institutionalization. *Amici* therefore suggest the following:

(1) That children placed for evaluation be housed in residential settings segregated from the general institutional population and in facilities used exclusively for children; *Cf., United States ex rel. Schuster* v. *Herold*, 410 F.2d 1071 (2nd Cir. 1969); *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973);

(2) That during the period of the evaluation, children should not be subjected to intrusive therapy modalities, *i.e.*, psychotropic drugs, electroconvulsive therapy, psychosurgery;

CONCLUSION

For the reasons set forth above, *amici* urge this Court to affirm the judgment of the court below.

Respectfully submitted,

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(3) That following the evaluation period children should be released from the mental institution to the custody of their parent or guardian. Any subsequent decision to seek commitment of the child must be preceded by the evidentiary hearing contemplated for commitment proceedings of all children.

Amici urge that older children, *e.g.*, 14 and over, should be provided with an evidentiary hearing to determine the appropriateness of a placement for observation and diagnosis, if they do not consent to it. Research into the cognitive and moral development of children gives credence to the legal claims of adolescents to participate in important decisions which affect their future. According to Jean Piaget, children from about the age of 12 possess the ability to conceptualize and engage in abstract reasoning and can apply such reasoning to situations in which they are personally involved. And while parents obviously continue to maintain a strong interest in the upbringing of their adolescent children, they must necessarily cede an increasing measure of control over their destinies to the children themselves. *See*, J. Piaget, The Moral Judgment of the Child (1965); J. Piaget, The Origins of Intelligence in Children (1952); Piaget, *Intellectual Evolution from Adolescence to Adulthood*, 15 Human Devel. 1-12 (1972).

• Counsel for *amici* wish to express their appreciation to law students Kay Rigling and Teri Sklar for their assistance in the preparation of this brief.

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No. 75-1690

In the Supreme Court of the United States

OCTOBER TERM, 1977

JAMES PARHAM, INDIVIDUALLY AND AS COMMISSIONER OF DEPARTMENT OF HUMAN RESOURCES, ET AL., APPELLANTS

v.

J. L. AND J. R., MINORS, ETC.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

MOTION OF THE UNITED STATES FOR LEAVE TO FILE BRIEF AMICUS CURIAE

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The Solicitor General, on behalf of the United States, moves this Court for leave to file a brief as *amicus curiae* after the time limit specified by Rule 42(2). Cf. Rule 42(4).

1. This case presents important issues concerning the method by which parents and guardians may seek mental health treatment for minors within their custody, as well as the obligations of the State to those minors placed with them for care. This is the second time in two terms that this Court has granted review of a case challenging state procedures for the commitment of minors to mental hospitals. See *Kremens*

v. *Bartley,* 431 U.S. 119. The United States filed a brief *amicus curiae* in *Kremens.*

2. This case not only involves the issues involved in *Kremens, supra,* concerning initial commitment, but also raises questions concerning the State's responsibility for providing subsequent treatment and placement for the committed child. Those questions required consideration of novel and difficult legal and policy issues upon which the United States has not previously taken a position. The resolution of the issues in this case may well have a substantial impact on future development of the law concerning commitment and treatment of minors in mental health facilities. As explained at pp. 2–3 of our brief (lodged with the Clerk simultaneously with this motion), the United States has a substantial interest in safeguarding the rights of minors, as well as the rights of all those placed in mental institutions.

3. The briefs of many amici filed under Rule 42 of the Rules of this Court limit themselves to a discussion of legal issues before the Court, and leave the discussion and development of the facts to the parties. The United States, however, customarily finds it necessary to make an independent review of the record in order to address the questions presented in light of the facts in the case. In this case, discussion of several issues required extensive review of the complex evidence in the record. Since the United States did not participate in the proceedings before the district court, the facts were not available to the United

States until the 950-page appendix was prepared by the parties. A copy of that appendix was made available on August 18, 1977, to the attorney in the Civil Rights Division who prepared the initial draft of the brief for the United States. The attorney also found it necessary to examine those portions of the record not in the Appendix; the full record was filed with the Court on August 29, 1977. Analysis of the facts, legal research, and preparation of a memorandum to the Solicitor General recommending *amicus* participation (see 28 C.F.R. 0.20) [1] consumed the period between August 18 and October 14, when most of the brief was submitted to the appropriate supervisors in the Civil Rights Division for their review.[2] The draft was approved within the Civil Rights Division on October 19, 1977.

4. The draft brief prepared by the Civil Rights Division was submitted to the Office of the Solicitor General on October 19, 1977. Since the issues presented have an impact on operations of facilities operated by the Department of Health, Education, and Welfare, a copy of the draft brief was submitted to that agency for its comments. The final revisions and

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[1] The Assistant Attorney General for the Civil Rights Division sent his recommendation to the Solicitor General on September 28, 1977. An Assistant to the Solicitor General made suggestions which necessitated further legal research and adjustments in the arguments advanced in the Division draft.

[2] During this time, the attorney in the Civil Rights Division also took a short, previously scheduled vacation and prepared a brief for the United States as appellant in the Fifth Circuit.

preparation of the brief by my staff necessitated additional review of the record in this case and the legal issues involved, as well as consultation with the Civil Rights Division regarding development of positions and arguments acceptable to both offices.

5. The brief was completed by this office on November 8, 1977. Final cite-checking and printing procedures prevented filing until this date.

6. Action on this brief was completed by the Civil Rights Division and by this office in as expeditious a manner as possible, considering the need to review the complex record and to consider the novel and difficult issues presented. Oral argument has tentatively been scheduled for December 6, 1977. There is sufficient time, however, between the filing of this brief and oral argument for the parties to address the arguments made by the United States, if they wish to do so.

Respectfully submitted.

WADE H. MCCREE, JR.,
Solicitor General.

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In the Supreme Court of the United States

OCTOBER TERM, 1977

JAMES PARHAM, INDIVIDUALLY AND AS COMMISSIONER OF DEPARTMENT OF HUMAN RESOURCES, ET AL., APPELLANTS

v.

J. L. AND J. R., MINORS, ETC.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

QUESTIONS PRESENTED

1. Whether, where the parents of a minor voluntarily place the minor in a state institution, there is sufficient "state action," including subsequent action by the state institution, to implicate the Due Process Clause of the Fourteenth Amendment.[1]

2. Whether the Due Process Clause of the Fourteenth Amendment permits statutory procedures authorizing the commitment to a state mental hospital

[1] This question was added by this Court when it noted probable jurisdiction on May 31, 1977 (App. 949).

of a minor on an application by the minor's parent or guardian approved by a designated state physician.

3. Whether the district court's order requiring the State to release certain class members who concededly could better be cared for in a non-hospital environment if it were available, and to provide facilities necessary to effectuate that release, was a proper exercise of the court's authority.

INTEREST OF THE UNITED STATES

The United States has a substantial interest in safeguarding the constitutional rights of those of its citizens least able to secure these rights on their own—the young and the mentally handicapped. This interest has led the United States to participate, both as *amicus curiae* and as a party, in many cases in which it sought to protect the rights of children and the mentally ill.[2] Last Term, the United States filed a

[2] See *O'Connor* v. *Donaldson*, 422 U.S. 563 (letter submitted to the Court); *Morales* v. *Turman*, 536 F. 2d 864 (C.A. 5) (*amicus curiae*), reversed and remanded, 430 U.S. 322; *New York State Association for Retarded Children, Inc.* v. *Carey*, 393 F. Supp. 715 (E.D. N.Y.) (full participation in all aspects of the case, including discovery and argument; hereafter "litigating *amicus curiae*"); *Davis* v. *Watkins*, 384 F. Supp. 1196 (N.D. Ohio) (litigating *amicus curiae*); *Horacek* v. *Exon*, 357 F. Supp. 71 (D. Neb.) (plaintiff-intervenor); *North Carolina Association of Retarded Children* v. *North Carolina*, 420 F. Supp. 451 (three judge court) (M.D. N.C.) (plaintiff-intervenor); *Halderman and United States* v. *Penhurst*, No. 74–1345 (E.D. Pa.) (plaintiff-intervenor); *United States* v. *Mattson*, decided September 27, 1976, 74–138 (D. Mont.), notice of appeal filed October 19, 1976; *Alexander and United States* v. *Hall*, 64 F.R.D. 152 (D. S.C.) (plaintiff-intervenor); *United States* v. *Solomon*, 419 S. Supp. 358 (D. Md.), affirmed, C.A. 4, No. 76–2814, decided October 12, 1977;

brief in *Kremens* v. *Bartley*, 431 U.S. 119, addressing some of the issues before the Court in the present case.[3]

Large sums of federal money are expended annually in the area of mental health care under, *inter alia*, the Community Mental Health Centers Act, 77 Stat. 290, as amended, 42 U.S.C. 2681 *et seq.*; and the Social Security Act, as added, Sections 1801 *et seq.* and 1901 *et seq.* (medicaid), (Medicare), 79 Stat. 291, 343, as amended, 42 U.S.C. 1395 *et seq.* and 1396 *et seq.* These expenditures reflect the interest of the United States in the improvement of mental health facilities; it has a correlative interest in ensuring that people who do not require confinement are not committed to facilities from which people requiring inpatient treatment may, therefore, be turned away. See S. Rep. No. 294, 90th Cong., 1st Sess. 3 (1967).

Gary W. and United States v. *Stewart*, No. 74–2412–C (E.D. La.) (plaintiff-intervenor); *Stockton and United States* v. *Alabama Industrial School*, No. 2834–N (M.D. Ala.) (plaintiff-intervenor); *Rone and United States* v. *Fireman*, No. 75–355A (N.D. Ohio) (plaintiff-intervenor); *Jenkins* v. *Cowley*, No. 3–74–394–C (N.D. Tex.) (litigating *amicus curiae*); *Stamus and United States* v. *Leonhardt and State of Iowa*, 414 F. Supp. 439 (S.D. Iowa) (plaintiff-intervenor); *Ewing* v. *Gaver*, No. C–74–147 (N.D. Ohio) (litigating *amicus curiae*); *Evans* v. *Washington*, No. 76–0293 (D. D.C.) (*amicus curiae*).

[3] In *Kremens*, this Court declined to reach the merits of the questions presented, and remanded for reconsideration of the class definition in light of intervening legislation and regulations (431 U.S. at 132–133).

STATEMENT

1. PROCEDURAL HISTORY

This action was brought on October 24, 1975, by two minors, J. L. and J. R., on behalf of a class of all persons younger than 18 who are now or hereafter received for diagnosis in or committed to State mental health facilities pursuant to Ga. Code Ann. 88–503.1 (a) (App. 1). That section states that:

> [T]he superintendent of any facility may receive for observation and diagnosis * * * any individual under 18 years of age for whom such application is made by his parent or guardian. * * * If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.[4]

Named as defendants were appellants herein—the Commissioner of the State Department of Human Resources, the Director of the Division of Mental Health, and the Chief Medical Officer of Central State Hospital (App. 3–4).

Appellees alleged that the operation of Section 88–503.1(a), the "voluntary" commitment statute, deprives them of liberty without due process, and therefore violates the Fourteenth Amendment (App. 11). Plaintiffs also alleged that continued confinement without consideration of placement in the "least drastic environment" was an additional violation of plaintiffs' due process rights (*ibid.*). The named plaintiffs each alleged that he had been committed to a Georgia state mental institution following application filed by his parent or guardian and that he did not then, and does not now, wish to remain in the institution (App. 5–9.)[5] Plaintiffs alleged that they were committed without a hearing or other procedural safeguards and that neither when they were committed, nor periodically during their confinement, have they been considered for placement in the "least drastic environment" (App. 7, 9). Plaintiffs alleged that continued confinement will result in harm to each (App. 6–9), and sought declaratory and injunctive relief as well as monetary damages (App. 12–14).

On November 18, 1975, the district court certified the action as one or behalf of a class of "all persons younger than 18 years of age now or hereafter received by any defendant for observation and diagnosis and/or detained for care and treatment" pursuant to Ga. Code Ann. 88–503.1(a) (App. 49).[6]

[4] The phrase "as may be authorized by law" is not specifically defined or further explained in the state code. However, the code does contain a section delineating the rights of patients during confinement. Ga. Code Ann. 88–502 *et seq.* (1971 rev.). Section 88–503.1(a) also permits the superintendent to recive any person over 18 on the person's own application, and any person legally adjudged to be incompetent on the application of a guardian.

[5] Appellee J L. was committed by his mother and stepfather (App. 5); appellee J. R. was committed by the Stephens County Department of Family and Children Services (apparently a division of the Georgia Department of Family and Child Service), his legal guardian (App. 7).

[6] In August 1976, appellee J. L. died, and this Court was promptly notified of his death. See Brief of Appellee 5. His death does not moot the case for class members admitted, as was J. L.,

A three-judge court was convened and, after receiving stipulated evidence and deposition testimony,[7] issued its opinion and order on February 26, 1976 (J.S. App. 1a–57a). The court held that the commitment of a child pursuant to Ga. Code Ann. 88–503.1(a) was a denial of liberty without due process (J.S. App. 53a); it declared the statute unconstitutional and enjoined further confinement of any child under 18 who had been admitted at the request of his parent or guardian pursuant to that statute (J.S. App. 56a). The court ordered the defendants within sixty days to initiate commitment proceedings for, or arrange to release, class members presently confined (J.S. App. 55a). The court also held that the State must provide less restrictive treatment facilities for 46 class members who, the defendants admitted,[8] could appropriately be treated in such facilities (J.S. App. 54a–55a). No damages were awarded.

Judgment was entered on March 11, 1976. Appellents' motion for a stay, filed on March 10, 1976, was denied by the three-judge court on March 17, 1976 (App. 937–946); this Court granted the stay on April 5, 1976 (425 U.S. 909). On May 31, 1977, probable jurisdiction was noted (App. 949).

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on the application of a parent. For those class members still institutionalized the case presents a live controversy. See *Sosna* v. *Iowa*, 419 U.S. 393, 399, 402. Cf. *Kremens* v. *Bartley*, *supra*, 431 U.S. at 130–133.

[7] The three-judge court also visited two of the state mental hospitals in which members of the plaintiff class are confined (J.S. App. 10a–11a).

[8] See p. 12, *infra*.

2. FACTS

Under the Georgia Code, minors under the age of eighteen may be committed to a State mental hospital upon the application of the minor's parent or guardian[9] if the responsible physician at the mental hospital determines that the child is in need of treatment. Ga. Code Ann. 88–503.1,(a).[10] At any one time, there are between 140 and 200 children in Georgia mental hospitals who were admitted pursuant to Section 88–503.1(a) (J.S. App. 13a–14a).

The precise manner in which a minor is admitted differs among the State's eight mental health facilities; however, in every instance the decision whether or not to accept the child for treatment is made by a physician employed by the State (App. 224; deposition of Dr. Douglas Skelton, Director of State Division of Mental Health).

That decision is based on interviews and recommendations by hospital or community health center staff.[11] The staff interviews the child and the parent

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[9] When a child has been removed from the custody of his parents, the Georgia Department of Family and Children Services (DFCS) may be given custody of the child. DFCS may then, as legal guardian, seek hospitalization for the child, as it did in the case of J.R. (App. 71).

[10] Under Section 88–503.1(b) of the Code, a minor 14 years old or older may make his own application for commitment.

[11] The superintendents of most of the regional mental hospitals testified that they preferred that the child first be brought by the parent or guardian to a local community health center (the community health centers provide outpatient care while the child remains in the home). When the child is presented to the community health center, he is interviewed by a member or members

or guardian who brings the child to the facility (App. 251–252, 284, 492). Although attempts are made to communicate with other possible sources of information about the child, such as a family physician or school personnel (App. 250, 284, 299, 467, 470), the primary source of information about the child is the parent or guardian (App. 299, 370, 569, 801). The staff recommends that a child should be hospitalized only after concluding that the child cannot be appropriately served by outpatient treatment provided by the health center while the child remains with his parents, or by placement in an available foster home.

When the child is first brought to a community health center, the interviews and accumulation of secondary information are usually done in one or two days, and a recommendation is reached within a day or two thereafter. If the recommendation is that the child be hospitalized, the child may be sent to the regional hospital for admission or a screening appointment (see note 11 *supra*). The decision on admission is usually made the same day a child is brought to the regional hospital, whether or not the hospital

of the staff, and a recommendation is made for outpatient treatment or hospitalization. Some regional hospitals admit *all* children for whom hospitalization is recommended by the community clinic (depositions of Dr. Donald Miles, Superintendent of Georgia Mental Health Institute, App. 271, and Dr. Eugene Jarrett, Superintendent of Southwestern State Hospital, App. 443), while some hospitals do a separate screening at the hospital even if hospitalization is recommended by the community clinic (depositions of Lawson Bowling, Superintendent of Georgia Regional Hospital at Atlanta, App. 357, and of Wladyslaw Mazur, Superintendent of West Central Georgia Regional Hospital, App. 479).

reinterviews children whose hospitalization is recommended by the clinic (App. 369). At no time prior to commitment of the child is the decision of the state physician subject to review by any independent authority.[12]

In most of the State's regional hospitals, when the child is admitted the staff attempts to devise a plan of treatment ultimately leading to return of the child to the parents (App. 360, 443, 481). Thereafter, there is no consistent state-wide policy regarding periodic review of the child's condition and necessity for continued confinement in the hospital. Nearly all the regional facilities perform a weekly staff review of each patient to determine the effectiveness of the treatment he is receiving and consider whether it should be modified. This review usually does not consider alternative placement for the child (App. 359, 450). The frequency of a more complete review of the child's progress differs from hospital to hospital.[13]

[12] Nor is there any specific provision for post-commitment review of his decision. Appellants assert that the validity of confinement may be judicially tested by the patient or his representative through a petition pursuant to Ga. Code. Ann. 88-502.11 alleging that the commitment procedures are being abused or questioning "the cause and legality of detention" (Brief 36–37).

[13] At Central State Hospital, for example, there is no regularly scheduled review, beyond regular staff meetings, of each child's condition (App. 312). At Southwestern State Hospital, there is a review by hospital staff and community staff at least monthly (App. 449–456), and a similar review of each case at the Georgia Regional Hospital at Augusta occurs at least every 100 days (App. 562, 563).

Release of the child following treatment depends upon the willingness of the parent or guardian to have the child returned. According to deposition testimony, some parents are unwilling to resume care of their child; the frequency of such reluctance was variously described as being "rare" (App. 561) and as occurring in as many as twenty-five percent of the cases (App. 365, 570). In the case of a child like J. R., who is already in the the legal custody of DFCS, release following treatment depends on the agency's ability to secure a foster home for the child. DFCS may also seek to secure foster care for a child whose parents are unwilling to accept him (App. 26). If no appropriate foster care is located, the child remains hospitalized.[14]

The "voluntary" admission statute permits anyone who has voluntarily admitted himself to a mental facility to secure his release by application. Ga. Code Ann. 88.503.3(a). Unless the superintendent moves to secure the patient's involuntary commitment (through

[14] The recommended treatment for J. L., and a number of others in the class, was "specialized foster care" (J.S. App. 21a, n. 18, see pp. 12–13, *infra*). Specialized foster care requires placement with "foster families selected to provide specialized foster care to disturbed children; such parents would be assisted through ongoing instruction from mental health workers in therapeutic management of their disturbed foster children" (App. 911). At the time of the district court decision, there were 13 such foster homes in the entire State, each of which could take no more than two children. Although 7 additional homes had been included in the DFCS budget for several years, no volunteer parents had been found. The court stated that the evidence indicated DFCS had not made substantial efforts to find them (J.S. App. 15a).

court procedures), the patient must be released. In the case of a minor, release on application is "conditioned upon consent * * * of his parent or guardian." Ga. Code Ann. 88–503.3(a). The statute also provides that the hospital "shall discharge any voluntary patient who has recovered from his mental illness or who has sufficiently improved that the superintendent determines that hospitalization of the patient is no longer desirable." Ga. Code Ann. 88.503.2.

Independent experts and employees of the State hospitals testified that long-term hospitalization is likely to have a detrimental effect on the development of a child (App. 30–34, 177–766, 804). This detrimental effect may include the development of behavior designed to succeed in the institutionalized setting ("colonization"), making the person less likely to be able to adapt to a non-institutional environment (App. 22–23), or the development of hostile and aggressive behavior that may lead to more psychological problems (App. 33, 178, 183).[15] Testimony also indicated that long hospitalization may

[15] One expert testified concerning the effects of continued hospitalization on J. L. and J. R. The expert stated that, for J. R., continued hospitalization "is not the optimal [setting] and in many respects could be detrimental" (App. 30). He described J. R. as "an excellent type of candidate for colonization" (*ibid.*). J. L., he testified, would also suffer from continued hospitalization, possibly developing more psychological problems due to hostile reaction to his situation (App. 33). Both J. L. and J. R., he testified, could benefit from alternative treatments, but such alternatives were not available, resulting in continued hospitalization (App. 30–34).

cause psychological damage to an individual's sense of self-worth, and may lead to a stigma, which in many cases will cause difficulty in later life (App. 177, 179, 512).

On January 24, 1976, in response to an inquiry from the court, the defendants submitted a letter showing that as of January 19, 1976, there were 46 hospitalized children in the certified class who, in the opinion of the hospital staff personnel, could "optimally [be] cared for in another, less restrictive, non-hospital setting if it were available" (J.S. App. 21a; see App. 760–761, 772).[16] For each of the 46, the particular optimal alternative care recommended (such as group home, specialized foster care, etc.) was specified (see J.S. App. 21a–22a). A report issued on November 9, 1973, by a commission appointed by the Georgia Division of Mental Health to study and recommend changes in the State's programs of mental health services for children found that a large number of children who were institutionalized[17] could be served in alternative facilities and recommended the establishment of numerous alternatives to hospitaliza-

[16] Both J. L. and J. R. were evidently in this group. See J.S. App. 21a, n. 18; App. 98, 109 (J.L.), 143, 145 (J. R.).

[17] The report appeared to refer to all children hospitalized, not only to those "voluntarily" admitted pursuant to Ga. Code Ann. 88.503.1(a). During 1973, when the report was issued, 639 children were admitted to hospitals, 458 voluntarily and 181 involuntarily (J.S. App. 12a–13a). The report stated that in three of five hospitals studied, "a majority of the children need not be hospitalized if alternative services were available in the community" (App. 915).

tion "which * * * do not exist at present in Georgia" (App. 900, 907–908).

3. DECISION OF THE DISTRICT COURT

The court concluded that the statute establishing the procedures for voluntary admission of children by parents and guardians unconstitutionally denied the children their liberty without due process of law. The court specifically held that the confinement of a child was a situation requiring the protections of due process (J.S. App. 49a) and concluded that "[n]either the statutory scheme nor the practices and policies utilized by the defendants provide for any procedural safeguards" (J.S. App. 46a–47a). The court rejected the State's argument that its statute merely assisted parents in carrying out parental responsibilities, holding that when the State acts, even in *parens patriae,* it must provide due process (J.S. App. 50a–51a). The court stated that requiring the protections of due process in this situation is not an "indictment of psychiatry" (J.S. App. 52a), but merely a recognition of the inexact nature of the science and the necessity for procedural safeguards designed to "guard against errors in judgment and/or arbitrariness that the best of us humans exhibit from time to time" (J.S. App. 52a). The court ordered the defendants to institute involuntary commitment proceedings under other statutes, including the Juvenile Court Act (Ga. Code Ann. 24A *et seq.,*) against each child in their custody, or to arrange for his release, within sixty days (J.S. App. 55a).

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The court found that the State has known since 1973 of the need for non hospital facilities for children who could be treated in such facilities (J.S. App. 52a). The court noted the State's belief that 46 children in the plaintiff class could optimally be cared for in alternative, non-hospital facilities if such facilities were available (J.S. App. 21a, 54a), and held that the State must provide appropriate non-hospital facilities for these children and place them in such facilities as soon as possible (J.S. App. 54a).[18]

Although the complaint prayed for a damage award, the court's remedial order made no provision for damages. Appellees have not asked this Court to review that omission.

SUMMARY OF ARGUMENT

The procedures authorized by the Georgia statute at issue here must conform to the due process clause of the Fourteenth Amendment, because the State is significantly involved both in the commitment of children to state mental institutions and in their treatment and retention once they have been committed. Although the initial request for commitment may be

[18] The court emphasized (J.S. App. 54a) that its order required the defendants to "*spend such money of the State of Georgia as is reasonably necessary to provide such non-hospital facilities and personnel*" (emphasis in original) and see J.S. App. 23a; App. 942. But the court also noted that the cost of accommodating a child in the alternative facilities would be substantially less than retaining him in the mental hospital (J.S. App. 23a; App. 943). Appellants evidently do not dispute this (see Brief for Appellants 52–53).

made by the child's parents, no child can be committed unless a state representative (a doctor at the receiving hospital) decides that the child needs treatment. That decision is sufficient to render the initial commitment State action for purposes of the Fourteenth Amendment. Since decisions concerning the child's treatment and other conditions of confinement are made by State agents, those decisions too are subject to scrutiny under the Fourteenth Amendment.

Commitment to a mental institution involves such substantial interference with the liberty of any person, whether child or adult, that state commitment procedures must provide due process to be consistent with the Fourteenth Amendment. Although persons who voluntarily consent to commitment waive these procedural protections, the potential for conflict between the interests of parent and child is too great to permit the parent to waive the child's personal constitutional right.

To determine the procedures constitutionally necessary to permit commitment of a child to a mental institution, it is necessary to balance the interests involved. All three participants in the process—parent, child, and State—are concerned that those children, and only those, who need institutionalization be confined, and that the procedures by which this is accomplished be as efficient and as non-burdensome as possible. In addition, the child has an independent interest in liberty, and the parent has an independent interest in the unhampered exercise of his responsibility for his child.

The current state procedures do not properly balance these various interests, since they permit the commitment of a child on the basis simply of interviews with the child and his parents, and provide no method by which any person adversely affected by the commitment may challenge it before an independent tribunal, either before or after commitment. In light of the constitutional inadequacy of the Ga. Code Arn. 88–503.1(a), the court correctly directed that available formal statutory procedures be followed in committing children to State mental institutions. The State remains free to promulgate alternative informal commitment procedures that satisfy the Fourteenth Amendment.

Finally, we submit that the question whether the State must provide alternative treatment facilities for certain class members is not ripe for decision by this Court, in view of the ambiguity concerning the legal rationale for this aspect of the court's order, and the paucity of the record supporting that order.

ARGUMENT

I. STATE ACTION IS PRESENT IN THE DECISION OF THE STATE'S PHYSICIAN TO COMMIT A CHILD TO A STATE FACILITY, PURSUANT TO STATUTORY PROCEDURES ESTABLISHED BY THE STATE LEGISLATURE

In order for the Fourteenth Amendment to apply to the commitment of children described in the Statement portion of this brief, the State must be "significantly involved" in the commitment process. *Reitman* v. *Mulkey,* 387 U.S. 369, 378. See also *Moose Lodge No. 107* v. *Irvis,* 407 U.S. 163, 172; *Jackson* v. *Metropolitan Edison Co.,* 419 U.S. 345, 349–351. That involvement may be either in initiating the process, or in substantially facilitating its completion once it has been privately initiated. *Shelley* v. *Kraemer,* 334 U.S. 1, 19–20; cf. *Fuentes* v. *Shevin,* 407 U.S. 67.[19]

The first step in the commitment of a child pursuant to Ga. Code Arn. 88–503.1(a) typically is the decision of a parent or guardian to seek commitment, a decision in which the State may not be involved. Of course, for children, like J. R., whose custody has previously been awarded to the State Department of Family and Children Services, the initial decision and all other steps in the process of commitment are taken by agents of the State. See n. 9, *supra;* App. 140. The commitment of such children unquestionably involves state action, and appellant does not suggest otherwise (Brief 21–25).

Even when the initial decision to seek to commit the child is made by his parent or private guardian, the agents of the State are significantly involved in the decision to commit, as well as the commitment itself. No child can be committed to a state hospital

[19] Section One of the Fourteenth Amendment prohibits the State from denying equal protection of the laws as well as from depriving persons of liberty without due process. Although most of the cases discussing the distinction between private and State action involve claims of racial discrimination, the standards expressed in those cases apply to a claim that the State has deprived one of liberty without due process. *Jackson* v. *Metropolitan Edison Co., supra,* 419 U.S. at 349–351.

pursuant to Section 88–503.1(a) without the agreement of the appropriate state hospital physician (App. 3664; see also App. 224, 261, 304).[20] If the state physician does not find that the child is in need of treatment, the child, regardless of the parents' wishes, will not be admitted to the State facility (App. 263, 305). 21/ This case therefore does not require the Court to consider whether a State's acqui-

[20] It is significant that actions of State officials are necessary before commitment can occur. In *Fuentes* v. *Shevin*, *supra*, without discussing the state action issue, the Court applied the Fourteenth Amendment to the action of a State court which, on application of a private party, had ordered the goods of another summarily seized. In *Adams* v. *Southern California First National Bank*, 492 F. 2d 324 (C.A. 9), a case in which a creditor seized property of a debtor without judicial intervention, the court of appeals held that there was no state action, noting that in *Fuentes* the state court's order supplied the state action bringing the transaction within the coverage of the Fourteenth Amendment. 492 F. 2d at 338. Cf. *Jackson* v. *Metropolitan Edison Co.*, *supra*, where this Court noted that no state officials had acted in support of the utility's termination of electrical service. See 419 U.S. at 355 and n. 15.

[21] Although, as appellants emphasize (Brief 23–24), the ultimate decision *not* to commit the child remains with the parent, it is the decisions to commit actually made in these cases, not hypothetical decisions to refrain from commitment, that are here alleged to violate the Fourteenth Amendment.

Appellants similarly argue that because the parents may always remove their voluntarily committed child from the state hospital, see Ga. Code Arn. 88–503.3, the State does not assert any right to detain the patient, and so the continued detention for treatment is private action, rather than State action. See Brief of Appellants 27. But the State, by retaining custody of the child in the absence of parental removal, has involved itself in the continued deprivation of the child's liberty; state action is present in the retention of the child as well as in the initial commitment.

escence in a purely private determination to commit a child to a state institution is state action implicating Fourteenth Amendment safeguards.

After commitment, state action continues; treatment is provided by the state hospital, where the child is physically detained. Decisions on treatment and the conditions of confinement during the child's period of hospitalization are all made by agents of the State employed at the state hospital. Such acts of state hospital employees are actions of the State and subject to scrutiny under the Fourteenth Amendment. See *O'Connor* v. *Donaldson*, 422 U.S. 563, 576; *Spence* v. *Staras*, 507 F. 2d 554 (C.A. 7).

These procedures unambiguously and significantly involve State officials in the commitment, detention, and treatment of a voluntarily committed child. Even when the initial decision to seek treatment is privately made, the remaining significant events are all ordered, and enforced, by agents of the State. Such action places the power of the State behind the commitment of the child, and places at least the approval of the State on the decision to commit the child. The deprivation of liberty, ordered and enforced by state officials, who assume custody of the child, is therefore subject to application of the Fourteenth Amendment. Here, as in *Shelley* v. *Kraemer*, *supra*, 334 U.S. at 19, it is the "active intervention of the state" that has resulted in the challenged deprivation of liberty.[22]

[22] Although *Shelley* v. *Kraemer* involved the intervention of a state court, its principles are not limited to state action solely by state courts. See *Moose Lodge No. 107* v. *Irvis*, *supra*, 407 U.S. at 172.

And here, as in that case, the State's active intervention, in bringing about a result that would not occur but for that intervention, is sufficient to transform the privately initiated activity into conduct subject to the Fourteenth Amendment.[23]

[23] The question whether commitment to private hospitals would implicate the Fourteenth Amendment is not presented by this case, since the class includes only children detained in state hospitals J.S. App. 55(a). The record contains no discussion of children who are committed to private hospitals in Georgia.

The coverage of the statute at issue here, Ga. Code Arn. 88–503.1, is not limited to public facilities. The statute applies to a "facility," which is defined in Ga. Code Arn. 88–501(c) to include state and federal hospitals "utilized for the diagnosis, care, treatment, training or hospitalization of persons who are mentally ill * * * and any other hospital within the State of Georgia approved for such purpose by the [Georgia] Department [of the Public Health]". In addition, Section 88.508.6 states that when any private facility is approved by the State as a private emergency, evaluating, or treatment facility, it "should have all powers given to the corresponding type of facility under the provisions of this Chapter on voluntary admission * * *, and shall have all duties and obligations of such facilities imposed by this Chapter."

Both parties suggest that a commitment of a child to a private hospital would be wholly free of Fourteenth Amendment scrutiny. See Brief of Appellants 25; Brief of Appellees 13. But that may not be correct. Both *Peterson* v. *City of Greenville*, 373 U.S. 244, 248, and *Adickes* v. *S. H. Kress & Co.*, 398 U.S. 144, 170, suggest that actions of private entities that serve as one method of enforcing, or implementing, policies adopted by the State, are state actions. And in *Doe* v. *Charleston Area Medical Center, Inc.*, 529 F. 2d 638 (C.A. 4), a private hospital's refusal to perform a nontherapeutic abortion requested by a patient was held to be state action because the hospital based its policy on a state law which, under criminal penalty, permitted only therapeutic abortions. See also *Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52 (applying the Fourteenth Amendment to a State's conferral of veto power on parents over the performance of abortions by private physicians).

This Court's opinions in *Jackson* v. *Metropolitan Edison Co.*, *supra*, and *Moose Lodge No. 107*, *supra*, suggest that the existence

Some cases have suggested that when the action at issue does not involve racial discrimination, a more stringent standard of state involvement should be used to determine whether the action is subject to scrutiny under the Fourteenth Amendment. See *Lucas* v. *Wisconsin Electric Power Company*, 466 F. 2d 638 (C.A. 7), certiorari denied, 409 U.S. 1114; *Adams* v. *Southern California First National Bank*, 492 F. 2d 324, 329 (C.A. 9). In these cases, the courts of appeals held that for private actions of a non-racial nature to implicate the Fourteenth Amendment, there must also be state action that affords

> affirmative support, [which] must be significant, measured either by its contribution to the effectiveness of [the private party's] conduct, or perhaps by its defiance of conflicting national policy.

Lucas, *supra*, 466 F. 2d at 656; *Adams*, *supra*, 492 F. 2d at 335.

of state action may depend on establishment of a "nexus" between the State law or regulation and the private action involved. See *Jackson*, *supra*, 419 U.S. at 351, and *Moose Lodge No. 107 supra*, 407 U.S. at 176. If the commitment is done pursuant to procedures statutorily prescribed, the "nexus" requirement may well be satisfied.

On the other hand, the cases cited at note 20, *supra*, suggest that when the State enacts laws that codify existing private remedies, private action taken pursuant to such laws is not state action. It might therefore be necessary to determine whether the intent of the legislature in enacting Section 88–503.1(a) was to codify existing laws concerning the commitment of children or to establish new rights and responsibilities.

Assuming, *arguendo,* that *Adams* and *Lucas* are correct, we believe the actions of the state authorities in this case satisfy the standard they define. A parent's decision to commit his child to a state facility is effective only if the State physician determines that the child may be admitted. This determination necessarily marks the commitment process as state action.

II. THE STATUTORY PROCEDURES FOR PERMITTING COMMITMENT OF CHILDREN ON APPLICATION OF A PARENT OR GUARDIAN VIOLATE THE DUE PROCESS RIGHTS OF THE CHILD

A. THE PROTECTIONS OF DUE PROCESS APPLY TO THE CIVIL COMMITMENT OF CHILDREN TO STATE MENTAL INSTITUTIONS

This Court has held that the civil commitment of an individual, entailing a deprivation of the individual's liberty, is subject to the Due Process Clause of the Fourteenth Amendment. *Specht* v. *Patterson,* 386 U.S. 605, 608. Although in *Specht* the commitment was based on the criminal nature of the defendant's acts, commitment for treatment purposes is also subject to constitutional strictures. As Chief Justice Burger pointed out in his concurring opinion in *O'Connor* v. *Donaldson,* 422 U.S. 563, 580, involving an individual who had been civilly committed for treatment:[24]

> There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law. *Specht* v. *Patterson,* 386 U.S. 605, 608 (1967). Cf. *In re Gault,* 387 U.S. 1, 12–13 (1967). Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding.

[24] As the Court noted (*id.* at 565–566 and n. 2), the record in that case was not entirely clear concerning whether Donaldson was committed for treatment or because he might harm himself or others. There was, however, evidently no suggestion that he had committed any criminal act.

The fact that the individuals to be committed are children does not, by itself, make constitutional protections any less applicable. "Minors, as well as adults, are protected by the Constitution and possess constitutional rights," *Planned Parenthood of Missouri* v. *Danforth,* 428 U.S. 52, 74. See also *In re Gault,* 387 U.S. 1; *Ingraham* v. *Wright,* 430 U.S. 651, 664–666, 672–676.

Appellants argue that a child has no independent right to challenge the decision of his parents that he should be committed to a mental institution, since, they suggest, that decision is not significantly different from the decision that the child should undergo treatment for a physical ailment (Brief 14–21).[25] But we believe the differences in the two situations

[25] Although we know of no case law suggesting that parents may not obtain treatment for physical ailments of their minor children against the wishes of the children, this Court has held that a State may not enforce a parental *veto* of a minor child's decision to have an abortion. See *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52.

may indeed be significant. The greater long-term loss of freedom, the danger facing a healthy person who is erroneously confined to a mental institution, and the greater stigma attached to hospitalization for mental disorders require greater attendance to procedural safeguards. See *Morrissey* v. *Brewer,* 408 U.S. 471, 481. These considerations, plus the peculiar difficulties of diagnosis and prognosis in the field of mental disorders (including the difficulty in some circumstances of determining which member or members of a family, if any, are in need of treatment), strongly indicate the need for independent review of parents' decisions to confine their children to mental institutions. Cf. *Greenwood* v. *United States,* 350 U.S. 366, 375.

B. A PARENT MAY NOT WAIVE THE PROCEDURAL PROTECTION TO WHICH HIS CHILD IS ENTITLED

This Court has recognized that a child's parent or guardian has the primary responsibility for directing the child's growth and development. In so directing his child, the parent is to be free of unreasonable governmental interference. "The child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations." *Pierce* v. *Society of Sisters,* 268 U.S. 510, 535. Cf. *Wisconsin* v. *Yoder,* 406 U.S. 205. Moreover, as a purely practical matter, when there is no substantial likelihood of a conflict of interest between

the parent and child, it is reasonable to assume that the parent possesses and the child lacks the maturity and experience that responsible decision-making requires, and that the child's dependency on the parent makes it appropriate to rely on the parent's decisions. Cf. *Smith* v. *Organization of Foster Families,* No. 76–180, decided June 13, 1977, slip op. 24–25, n. 44.

The situation is different when there is a significant likelihood of conflict. In *Prince* v. *Massachusetts,* 321 U.S. 158, this Court upheld the right of the State to regulate child labor in the face of a parental decision asserting a right to direct a child's religious training.[28] The State's finding that the rigors of child labor may have a harmful effect on children was held to justify the exercise of the State's authority (321 U.S. at 168–169), notwithstanding the parental desires to the contrary. Moreover, when parental authority has been upheld against interference by governmental authorities, this Court has emphasized that the parents' actions did not appear to conflict with the interests of the child. *Wisconsin* v. *Yoder, supra,* 406 U.S. at 229–

[28] Although in *Prince* the parental decision was made by the child's custodian, her aunt, the Court drew no distinction on that basis, and the same principles would seem to apply, whether the decision is made by a parent or an individual custodian or guardian. The considerations may, however, be quite different when the decision is made by a state agency acting as legal guardian. As appellees note (Brief 36), the interest of family privacy and autonomy is absent in those cases, as is the possibility, discussed *infra,* that the decision to request institutionalization for the child may itself be a pathological parental reaction.

234; *Meyer* v. *Nebraska,* 262 U.S. 390, 400. Finally, where the conflict is explicit, the Court has held that the State may not condition the exercise of the minor's rights on parental consent. In *Planned Parenthood of Missouri* v. *Danforth,* 428 U.S. 52, 74–75, the Court concluded that a state statute prohibiting any minor from obtaining a nontherapeutic abortion with parental consent unconstitutionally restricted the minor's right to privacy in favor of parental authority. At least in that situation "where the minor and the nonconsenting parent are so fundamentally in conflict * * * [a]ny independent interest the parent may have in [the decision] * * * is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant" (*id.* at 75). Although some of the minors involved in this case may be younger and less competent than those in *Danforth,* they are no less entitled to judicial recognition of their independent constitutional rights when those rights conflict with the interests of their parents.[27]

The record here supports the district court's conclusion that a parent's decision to seek commitment for his child may conflict with the child's best interests (J.S. App. 39a–40a; App. 35–36, 163, 266, 371, 473).[28]

[27] It may be that a very young child has an insubstantial right of privacy vis-a-vis his parents, but it does not follow that his right not to be confined in a mental institutional without due process of law is similarly limited.

[28] The district court in *Kremens* credited similar testimony, stating that, "[i]n deciding to institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interests of their children." *Bartley* v. *Kremens,* 402 F. Supp. 1039, 1047–1048 (E.D. Pa.) (three-judge court), dismissed as moot *sub nom. Kremens* v. *Bartley,* 431 U.S. 119.

The conflict may arise either because the parent more or less rationally decides to sacrifice the child's interests to his own needs,[29] or because the parent is himself in need of psychiatric treatment. The court summarized the record testimony as showing that (J.S. App. 39a; footnote omitted):

> "[I]t's by now a truism in child psychiatry, a truism built over maybe fifty years of clinical experience in a wide variety of settings, that the pathology of children is inextricably related to the pathology of the family. . . ." More often than not the parents as well as the child might need psychiatric help.

In these circumstances, the district court properly concluded that due process "necessarily includes procedural safeguards to see that even parents do not use the power to indefinitely hospitalize children in an arbitrary manner" (J.S. App. 51a), whether that power is rationalized as a waiver of their children's rights,[30] or as the performance of their duty to maintain, protect and educate their children (J.S. App. 49a).

[29] For example, one of the reasons J. L.'s mother wished to commit her son was his disruptive effect on her second marriage (App. 60, 96).

[30] This was the asserted rationale in *Kremens, supra* (see Government Amicus brief 13).

C. THE GEORGIA PROCEDURES FOR VOLUNTARY COMMITMENT OF CHILDREN DO NOT PROVIDE DUE PROCESS

After it is determined that due process attaches, the specific process to be provided must be determined. "Due process is flexible and calls for such procedural protections as the particular situation demands." *Morrissey* v. *Brewer*, 408 U.S. 471, 481.[31]

In *Mathews* v. *Eldridge*, 424 U.S. 319, 334–335, this Court summarized the factors to be considered in determining whether existing procedures supply the degree of due process required in a given situation:

> Our prior decisions indicate that identification of the specific dictates of due process generally requires consideration of three distinct factors: first, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

[31] While not determinative here, the due process standards promulgated in adult commitment and juvenile delinquency cases are instructive in deciding what process is due juveniles confined to mental health facilities, for the deprivation of liberty and the potential consequences are similar.

In the context of commitment of adults to mental health facilities, courts have held that due process requires an opportunity for a hearing on the need for confinement. See *In re Ballay*, 482 F. 2d 648 (C.A. D.C.); *In re Barnard*, 455 F. 2d 1370 (C.A. D.C.); *United States ex rel. McGurrin* v. *Shovlin*, 455 F. 2d 1278 (C.A. 3). In juvenile delinquency commitment proceedings, the juvenile is entitled to notice and a hearing with counsel, the right to confront and cross-examine witnesses, and to remain silent. *In re Gault*, *supra*. He is not entitled to a jury. *McKeiver* v. *Pennsylvania*, 403 U.S. 528.

See also *Smith* v. *Organization of Foster Families*, No. 76–180, decided June 13, 1977, slip op. 32.

The private interests affected here are those of the child and of his parents: both are interested in assuring that a child who needs the treatment he can receive in a mental institution receives that help as promptly as possible, and without unnecessary potentially traumatic procedures. The child has, in addition, a discrete and substantial individual interest in not being unnecessarily institutionalized. Cf. *In re Gault, supra*.[32] The parent has a discrete interest in freedom from State interference with his decisions regarding the custody and control of his child (cf. *Wisconsin* v. *Yoder, supra*). These interests do not necessarily conflict with the State's interest in assuring that those children, and only those, who require or will benefit from institutionalization are confined, and that the procedures by which this is accomplished are as efficient as possible. None of these

[32] In addition to the immediate denial of liberty resulting from commitment, hospitalization may result in a stigma that follows the child even after release, *In re Ballay*, 482 F. 2d 648, 667–669 (C.A. D.C.), as well as danger to the child's development, *Shuster* v. *Herold*, 410 F. 2d 1071, 1078 (C.A. 2); *Matthews* v. *Hardy*, 420 F. 2d 607, 611 (C.A. D.C.); App. 143, 177, 183, 297.

interests is insignificant. Accordingly, due process requires that each be accommodated in the procedures adopted.

The second factor here is the risk that the current procedures permit the confinement of juveniles who do not require and will not benefit from institutionalization, and the probable value, if any, of specific additional procedural safeguards in minimizing that risk. Finally, the additional burden of the proposed supplementary procedures on the State's mental health and judicial systems must be considered.

The challenged statute provides for the commitment of a child on the request of his parent or guardian if the child is "found to show evidence of mental illness and to be suitable for treatment" (Ga. Code Ann. 88–503.1(a)). In practice, the determination of suitability for treatment is made by the responsible physician at the State institution to which application for commitment is made. Although the doctor acts on the basis of interviews with the parent or guardian and the child, and whatever secondary material is available,[33] and thus after what is in some respects an

[33] Several witnesses testified concerning the method of gathering the information on which the commitment is ordered. All the medical witnesses, including superintendents of regional health centers, indicated that the primary source of information on which a decision to commit the child is based on the parents (App. 299, 370, 569, 801). The information secured from secondary sources, such as schools, is unverified (App. 263, 369, 472), and in some instances decisions on admission are reached even though information from secondary sources may not yet have been secured (App. 284).

informal hearing, his determination that commitment is appropriate is practically unreviewable.[34] Moreover, once the child has been institutionalized, there may be no regularly scheduled consideration of whether he has improved sufficiently to be released (see *supra*, p. 9).

The court of appeals concluded that the challenged statute "supplies not the flexible due process that the situation of the plaintiff children demands but instead, absolutely no due process" (J.S. App. 53a). It evidently based this conclusion on its finding that "children are institutionalized without a hearing or other procedural safeguards; are hospitalized without initial or periodic consideration of placement in the least drastic environment necessary for treatment; and are not afforded a hearing at any time for the determination of an appropriate required time for discharge" (J.S. App. 47a). Rather than attempt to define the minimum procedures required by due process in this situation, the court required appellants to conform to existing state procedures for involuntary or juvenile court commitments (J.S. App. 55a).[35]

We believe that there is a constitutional defect in the current procedures, since they provide no method by which any person adversely affected by the commitment order may challenge it before an independent tribunal, either before or after commitment. Cf. *Goldberg* v. *Kelly*, 397 U.S. 254, 271; *Morrissey* v. *Brewer*,

[34] Cf. note 12, *supra*.

[35] These procedures are summarized at J.S. App. 33a–38a.

408 U.S. 471, 482. This "unbridled discretion" (J.S. App. 47a) vested in the admitting physician unnecessarily restricts appellees' liberty interests. Affording the opportunity for such review would not, in our view, significantly impinge on the interests of the parents or the State [36]—indeed, to the extent that it increases the chance that no one will be unnecessarily confined, it serves those interests. Nor would providing for such a right to review appear to impose an undue burden on the State's mental health or judicial systems. The number of hearings potentially involved is not large.[37] The court below required that all children be admitted pursuant to alternative procedures already available, noting in denying a stay that the proceedings required should not create a problem for the Georgia juvenile court system that disposed of 48,116 cases in 1974 (App. 941).[38] But if the currently available procedures do prove burdensome,[39] the State is free to adopt less elaborate ones, so long as they permit an effective appeal to an independent tribunal from the physician's decision to admit a child

[36] To the extent that a formal hearing might harm certain children, the existing statutory procedures permit the hearing to be "held in as informal a manner as possible and in a setting which is not likely to have a harmful effect on the mental health of the patient" (Ga. Code Ann. 88–307.3(f)).

[37] In fiscal year 1974, 515 children were admitted to Georgia state mental institutions pursuant to the challenged procedures (J.S. App. 12a); 154 such children were in custody on January 31, 1976 (App. 941).

[38] Indeed, the court suggested (J.S. App. 40a–41a) that state law may itself require that children in the custody of DFCS be admitted only pursuant to juvenile court procedures.

[39] See App. 918–933.

to a mental institution at the request of his parent or guardian.[40]

III. THE RECORD IS INADEQUATE FOR THIS COURT TO DETERMINE THE PROPRIETY OF THE DISTRICT COURT ORDER REQUIRING THE STATE TO PROVIDE ALTERNATIVE FACILITIES

Appellants' third question presented is whether they may be required to provide "needed mental health services in the most optimally appropriate treatment setting commensurate with the minor's condition" (J.S. 6). We do not believe that this question is ripe for review in this case. It is not clear from the opinion below whether the court concluded that the failure of appellants to assure that appellees were placed in "the least drastic environment necessary for treatment" was an independent violation of their due process rights (J.S. App. 47a, 52a) or whether its direction to provide "whatever non-hospital facilities are deemed by [appellants] to be most appropriate" for the 46 identified children [41] was simply an exercise of its equitable power to require appellants to remedy the effects on the appellees of the initial denial of procedural due process, or of unjustified continued confinement of the identified children (J.S. App. 53a–54a).

Moreover, the record is inadequate for this Court to determine whether the court's order is appropriate

[40] In order to be effective, the procedures might have to provide for the appointment of a person to represent the child's interests, at least when the child is very young or very ill.

[41] See *supra*, p. 12.

under either interpretation."[42] Appellants answered the court's request " 'to designate the situation in which they would like to see the child placed in order to get optimal benefits' " by identifying 46 children who could be released from the hospital if other facilities were available (J.S. App. 21a). But neither this exchange nor the rest of the record reveals whether continued confinement of appellees in State mental hospitals bears "some reasonable relation to the purpose for which the individual was committed," as required by *Jackson* v. *Indiana,* 406 U.S. 715, 738. The absence of such a reasonable relationship could itself require the State to place those children in situations that afford them the freedom appropriate for a child whose mental condition does not require hospitalization. *Jackson* v. *Indiana, supra;* cf. *O'Connor* v. *Donaldson,* 422 U.S. 563, 575. If there was no such reasonable relation, it would be unnecessary to reach the questions whether the identified alternative placements were less restrictive than confinement in the mental institution, and, if so, whether there is a substantive due process right to treatment or to the least restrictive appropriate confinement.

[42] The record, for example, does not describe the differences between the conditions of confinement and the degree of freedom permitted a child in a hospital, as compared to a child placed in specialized foster care, a group home, therapeutic camp life, or other non-hospital placement (see J.S. App. 18a–19a, 54a). In addition, it is not clear whether, for those children for whom state hospital officials recommended placement in non-hospital facilities, it is, as for J. R., merely the lack of available facilities that caused their continued confinement, or whether other factors were present.

If those questions are nonetheless to be reached, the record should be supplemented with regard to the former (see, *e.g.,* Brief of Appellants 48–49[43]) and this Court should have the benefit of an explanation of the legal basis for the district court's views on the novel and difficult issues involved in the latter.

Alternatively, if the court's order is simply an exercise of its equitable remedial powers, the propriety of the order would depend on an evaluation of the factors identified in *Milliken* v. *Bradley,* No. 76–447, decided June 27, 1977 (slip. op. 12–13; emphasis supplied):

> In the first place, like other equitable remedies, the nature of the * * * remedy is to be determined by the nature and scope of the constitutional violation. * * * The remedy must therefore be related to "the condition alleged to offend the Constitution. . . ." Second, the decree must indeed be *remedial* in nature, that is, it must be designed as nearly as possible "to restore the victims of discriminatory conduct to the position they would have occupied in the absence of such conduct." * * * Third, the federal courts in devising a remedy must take into account the interests of state and local authorities in managing their own affairs, consistent with the Constitution. [Footnotes omitted.]

In light of the ambiguity of the opinion and the paucity of the record, we submit that it is appropriate that the district court make those evaluations in the

[43] Moreover, the record does not show what is meant by the "residential treatment" recommended for 11 of the children (J.S. App. 21a–22a, n. 18), and it is thus not clear whether that is a less restrictive form of treatment.

first instance, if indeed it intended that its order be simply remedial.

Finally, it is not clear whether the district court found that due process requires the periodic hearings to assure that the child still requires hospitalization that are required under the alternative statutory procedures that appellants were directed to utilize (see J.S. App. 34a, 38a). Nor is it clear that the questions presented in the jurisdictional statement reasonably comprehend any such finding the court may have made. If the Court concludes that that issue is before it, we believe it would also be proper to require the district court to clarify that question on remand, particularly since its conclusions on that matter may be affected by the scope of the determination concerning alternative treatment facilities.

CONCLUSION

For the foregoing reasons, the order of the court below should be remanded for further consideration of the need to provide alternative treatment facilities and to conduct periodic reviews of the need for continuing hospitalization, and affirmed in all other respects.

Respectfully submitted.

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